PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The

MARGIN RESERVED FOR BINDING

VS. A15 -- 10 - 53

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda Rural LENGTH OF STA (in this place) TOWN Bethesda Rural 1 mo 6 day HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital 3. NAME OF (First) (Middle) DECEASED: (Type or Print) Ralph Douglas	OR	and give nearest town
CITY (If outside corporate limits, write RURAL or and give nearest town) Bethesda Rural HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital 3. NAME OF (First) (Middle) DECEASED: Delab.	CITY(If outside corporate limits, write RURAL OR TOWN Dumfries STREET (If rural give location ADDRESS	83x-3
CITY (If outside corporate limits, write RURAL or and give nearest town) Bethesda Rural HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital 3. NAME OF (First) (Middle) DECEASED: Delab.	CITY(If outside corporate limits, write RURAL OR TOWN Dumfries STREET (If rural give location ADDRESS	83x-3
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital 3. NAME OF (First) (Middle) DECEASED: Polyplas	STREET (If rural give location)
3. NAME OF (First) (Middle) DECEASED: Delinh Dougles	O2 TLTDOTT WETRICE	. /
DECEASED: Delah Douglas		V
	ADAMS ADAMS ADATE (Month) OF DEATH: May	(Day) (Year) 19 19 55
5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DAT	TE OF BIRTH: 9. AGE last birthday IF UNDER 1	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): 12.	CITIZEN OF WHAT
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	
Ray F. ADAMS	Margaret A. TANKESLEY	
(Yes no, or unk.) (If Yes, give war or dates of service)	Father Capt Ray F. ADAMS USM Same as above	;
18. MEDICAL CERTIFIC	ATION	INTERVAL BETWEEN
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	0. 1	ONSET AND DEATH
IMMEDIATE CAUSE	e Juliure	/ month
ANTECEDENT CAUSE (S)	West Diease Transposition of	
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. OUE TO GREAT VESSEL OUE TO GR	lo TV Septel defect potenty	
(c) ducles +	caretition of arti)	2 mos.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE		
DISEASE OR CONDITION CAUSING DEATH. 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERAT	ION	20. AUTOPSY?
2		YES XX NO
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, for Contributing Cause of Death (IF either, notify medical examiner)	factory, 21c. WHERE DID (City or town) (Counding, etc. INJURY OCCUR?	nty) (State)
21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURR While While at work at work	RED 21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from13		
Asign Warea		stated above. TE SIGNED
TO TO PASCOR LT MC ISN H. S. NOVO HACTI	talp NNMC, Bethesda, Maryland	or county) (State
23. BURIAL, CREMATION. DATE THEREOF NAME OF CEM	ETERY OR CREMATORY LOCATION (City, town, or National Cemetery Arlington, Vi	

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4781 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEAT

	04752
	Reg. Dist.
H	No.

I. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:
COUNTY Montgomery MARYLAND	STATE Maryland county Montgomery
CITY (If outside corporate limits, write RURAL OR and give nearest town) (in this place) TOWN Silver Spring	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Silver Spring
HOSPITAL OR INSTITUTION OR 2023 Luzerne Avenue	STREET (If rural, give location) ADDRESS 2021 Luzerne Avenue
3. NAME OF (First) (Middle) DECEASED: William Russell A	(Last) (A. DATE (Month) (Day) (Year) OF DEATH May 30 1955
Male White Widowed, Divorced, (Specify Married 5/20	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Printer - Hand Govt. Printing	_COUNTRY?
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
William Antrim	Carolyn Rummell
/V on well \ / (If Von mine way on dates of)	17. INFORMANT & ADDRESS: Mrs. Laura B. Antrim, 2021 Luzerne Ave.
Antecedent cause(s) Diseases or conditions, if any, (b)	
DISEASE OR CONDITION CAUSING DEATH. 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY?
198. DATE OF OPERATION: 198. MAJOR PRODUCT OF BRATION.	Yes No 🗗
21a. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING OF Street, office bldg., etc. INJURY	
21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED While at Not while INJURY M. work □ at work □	21f. HOW DID INJURY OCCUR?
find that death resulted from: Natural causes , Accidental signature 23. BURIAL, CREMATION DATE THEREOF NAME OF CEMETER REMOVAL (Specify): 6/2/55 Arlington Natural causes , Accidental signature 24. Accidental signature 25. Accidental signature 26. Accidental signature 27. Accidental signature 28. Accidental signature 28. Accidental signature 29. Accidental signature 29. Accidental signature 20. Accidental signature 21. Accidental signature 22. BURIAL, CREMATION DATE THEREOF NAME OF CEMETER 23. Accidental signature 24. Accidental signature 25. Accidental signature 26. Accidental signature 27. Accidental signature 28. BURIAL, CREMATION DATE THEREOF NAME OF CEMETER 28. Accidental signature 29. Accidental signature	bed above, held an Autopsy , Inspection , Inquiry , and dent , Suicide , Homicide , Undetermined cause . CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM. RY OR CREMATORY LOCATION (City, town, or county) (State) Compared to the county Arlington, Virginia
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REG. 133	Warner to Pumphrey, Silver Spring Md.

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1 21 122 22 22 22 22	L o Hella Beelberge (House of Beerle	
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEAS	ED:
COUNTY MONTGOMETY MARYLAND	STATE Virginia COUNTY	
CITY (If outside corporate limits, write RURAL LENGTH OF ST (in this place)	OR	and give nearest town
X TOWN Bethesda Rural 2 days	TOWN Falls Church	83X-3
HOSPITAL OR SITTEET ADDRESS. S. Naval Hospital	STREET (If rural give location ADDRESS 2128 Arlington Bouleva	
3. NAME OF (First) (Middle)	(Last) 4. DATE (Month)	(Day) (Year)
(Type or Print) Thomas Preston	APPLEBY OF DEATH: MAY	21 19 55
RACE: WIDOWED, DIVORCED.	TE OF BIRTH: 9. AGE last birthday IF UNDER Months yrs.	Days Hours Min.
OA. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): 12 Bethesda, Maryland	COUNTRY?
3. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	
Dan P. APPLEBY	Joan SIMARD	
(Yes_no, or unk.) (If Yes, give war or dates of service) (Security No. 15. Social Security No. 15. Soc	Father LCDR Dan P. APPLEBY U	SN
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 1025 IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY. (B)	naturity	2 day
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)	4	9
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERAT	TION	20. AUTOPSY?
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, DR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office blocking the contribution of the	dg., etc. INJURY OCCUR?	inty) (State)
OF INJURY (Month) (Day) (Year) (Hour) 21E INJURY OCCUR While Not while at work at work	RED 21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 19	May , 19.55, to 21 May , 19.55, that I la	st saw the decease
alive on 21 May 1955 and the death occurred	at 8:15AM, from the causes and on the date ADDRESS D	e stated above. ATE SIGNED
M. S. ALLEN LT MC USN U. S. Naval Hospita	M. MIMC. Bethesda, Maryland ETERY OR CREMATORY LOCATION (City, town.	
REMOVAL (SPECIFY)	ETERY OR CREMATORY LOCATION (City, town. National Cemetery Arlington, Vir	

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VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

TEDICAL	EXAMINER'S	CERTIFICATE	OF	DEATH	No. 218

Gt	ATTITUDE DE LA CONTRACTION DEL CONTRACTION DE LA CONTRACTION DE LA CONTRACTION DE LA CONTRACTION DEL CONTRACTION DE LA C	keg. Dist.
orre	MEDICAL EXAMINER'S CERTIFICATE OF DEATH	No. 21. E
စ	1. PLACE OF DEATH: 2. USUAL RESIDENCE (HOME) OF DECEASED:	
T. Y.	COUNTY MONTH MARYLAND STATE MA COUNTY MONTH	
f information carefully. The correct death clearly and legibly.	CITY (If outside corporate limits, write RURAL OR and give nearest than) TOWN CITY (If outside corporate limits write RURAL and OR TOWN Southern Learn (in this place) TOWN Lasthern Learn (In this place)	give nearest town)
n care	HOSPITAL OR STREET ADDRESS Mt. Pleasant avz STREET ADDRESS Mt Pleasant avz	1
matio	3. NAME OF (First) (Middle) (Last) 4. DATE (Month) (Day) DECEASED: (Type or Print) Charles Beng. (Wirrold DEATH May 28	1955
infor	5. SEX: 6. COLOR OR RACE: WIDOWED, DIFORCED, S. DATE OF BIRTH: 9. AGE last birthday: 4 UNDER 1 Y. Months Da	ys Hours Min.
5 00	10a. USUAL OCCUPATION (Give kind of work life, even if retired): INDUSTRY: 11. BIRTHPLACE (State or foreign country): 12. 12. INDUSTRY:	COUNTRY?
every item ne causes	13. FATHER'S NAME:	
BIN	R. Benj. Cirnold Inknown	
R A e	15. WAS DECEASED EVENTIN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) 16. Social Security No.: 17. INFORMANT & ADDRESS: HA English - Manne an Ha	2
RESERVED FO NG INK. Suppl s: please write	I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:	INTERVAL BETWEEN ONSET AND DEATH
ESEI G IN	Immediate cause DUE TO	in bed
HE	Antecedent cause(s) Diseases or conditions, if any, (b)	
RG NF	stating underlying cause last (c)	1
	II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
WIT	19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes \(\text{No } \(\text{Q} \)
imp,	21a. EXTERNAL CAUSE WAS PRIMARY □ or CONTRIBUTING □ CAUSE OF DEATH. 21b. PLACE (Home, farm, factory, off street, office bldg., etc., INJURY 21c. (City or town) (County)	(State)
AIN	21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED While at Not while INJURY M. work \(\begin{array}{c ccccccccccccccccccccccccccccccccccc	
PI	22. I hereby certify that I took charge of the remains described above, held an Autopsy [], Inspection [2],	Inquiry Z, and
PLEASE WRITE PLAINLY, WITH age is especially important.	find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undeter SIGNATURE CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.	mined cause []. DATE SIGNED 5-28-55
SE I	23. BURIAL, CREMATION DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or co REMOVAL (Specify):	Li (State)
PLEA	DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REG. DIANA 31/955 Winds Cook Barber Joylo	ADDRESS
		ny

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MARYLAND	STATE	DEPARTMENT	OF	HEALTH—BALTIMOR	E,	18
4784	CEL	RTIFICATE	OF	DEATH	200	Die

CERTIFICATE OF DEATH

Reg Diet No 215

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery MARYLAND	STATE Georgia COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town) X TOWN Bethesda Rural LENGTH OF STAY (in this place) 5 weeks	CITY(If outside corporate limits, write RURAL and give OR TOWN MACON	nearest town
HOSPITAL OR SINSTITUTION OR U. S. Naval Hospital	STREET (If rural give location) ADDRESS 143 Rogers Avenue	/
3. NAME OF (First) (Middle) (DECEASED: (Type or Print) Bonnie Sue AWTREY	(Last) 4. DATE (Month) (Day) OF DEATH: May 28	(Year) 1955
	OF BIRTH: 9. AGE last birthday IF UNDER 1 YEAR IF Months Days H	ours Min.
work done during most of working life, even if retired): Housewife 10B. KIND OF BUSINESS OR INDUSTRY: Housewife Housewife	11. BIRTHPLACE (State or foreign country): 12. CITIZET COUNT Georgia U.S.	
Franklin C. DAVIS	14. MOTHER'S MAIDEN NAME: Susan CLEVELAND	
15. WAS DECEASED EVER IN U.S. ARMEO FORCEST (Yes. no, or unk.) (If Yes, give war or dates of service) NONE	Hugh R. Awtrey Washington, D. C.	.W.
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	s of the Lucr	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION	V 2O. YES	AUTOPSY7
and the second s	tory, 21c. WHERE DID (City or town) (County) etc., INJURY OCCUR?	(State)
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, facts of CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, facts of Control of Cont		(State)
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fact OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., (IF EITHER, NOTIFY MEDICAL EXAMINER) 21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while at work at work 1		(State)
21D. TIME (Month) (Day) (Year) (Hour) While Not while at work 21 attended the deceased from 4-24 alive on 28 17 11955., and that death occurred at SIGNATURF	21F. HOW DID INJURY OCCUR?	ne deceased above. ED

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

	MEDICAL EXAMINER				DEATH	No. 4
	I. PLACE OF DEATH:	2. U	SUAL RESIDENCE	(HOME) O	F DECEASED:	
	COUNTY Montgomery M.	ARYLAND S	STATE MA	COUN	TY Mont	4
and legibly	CITY (If outside corporate limits, write RURAL OR and give nearest town)	in this place) O	OWN S	porate limits	0 0	give nearest town)
	HOSPITAL OR ANSTITUTION OR RAD - Bot 1.	S'	TREET DDRESS R 3	1 (If r	ural, give location)	
cleariy	3. NAME OF (First) (Middle) DECEASED: (Type or Print) Cdww	Balling		DATE OF DEATH	(Month) (Da	y) (Year) -2- 1955
death		RCED, Oct 8	1871	8.3	yrs. Months I	YEAR IF UNDER 24 HRS. Hours Min.
OI	10a. USUAL OCCUPATION (Give kind of work done during nost of work life, even if retired). Turnels	OF BUSINESS OR ITRY:	1. BIRTHPLACE (State or for	eign country): I2	COUNTRY?
causes	13. FATHER'S NAME: Ballinge		Hannah	N NAME:	noore	
e the	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	SECURITY No.: 17. IN	WI A Ball	RESS:	(wife),	Browliele me
write		18. MEDICAL CE	ERTIFICATION	1	· ·	1 y
please w	I. DISEASES OR CONDITIONS DIRECTLY LEADING TO	DEATH:	lusion	V		INTERVAL BETWEEN ONSET AND DEATH
ple	Immediate cause (a)	7		******************	****************************	Alash
	Antecedent cause(s)	(/				acam
lan	Diseases or conditions, if any, (b)	V			****************************	***
Physicians:	stating underlying cause last (c)					
P3						
	II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
	TO THE DEATH BUT NOT RELATED TO THE	OPERATION:				20. AUTOPSY? Yes \(\sum \) No \(\sqrt{2} \)
important.	TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF 21a. EXTERNAL CAUSE WAS OF STREET OF STREET OF CAUSE OF DEATH.	operation: ne, farm, factory, t, office bldg., etc.,	21c. (City or town)		(County)	
important.	TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF PRIMARY OF CONTRIBUTING OF STREE CAUSE OF DEATH. 21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OF INJURY 21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY While at work OF INJURY WORLD WORD WORLD WOR	operation: ne, farm, factory, t, office bldg., etc., COCURRED Not while at work	21c. (City or town)		:1	Yes No (State)
especially important.	TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF PRIMARY OF CONTRIBUTING OF Stree INJURY 21a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING OF STREE INJURY 21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY While at work OF INJURY 22. I hereby certify that I took charge of the refind that death resulted from: Natural causes.	operation: ne, farm, factory, t, office bldg., etc., COCCURRED Not while at work emains described a	21c. (City or town) 21f. HOW DID INJU above, held an A	utopsy [] Homicic	, Inspection ⊠	Yes No (State) (State) , Inquiry , and ermined cause .
is especially important.	TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF PRIMARY OF CONTRIBUTING OF STREE CAUSE OF DEATH. 21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY While at Work OF INJURY 22. I hereby certify that I took charge of the results of the second of the secon	operation: ne, farm, factory, t, office bldg., etc., COCCURRED Not while at work emains described a	21c. (City or town) 21f. HOW DID INJU above, held an A Buicide , CHIEF M DEPUTY	utopsy Homicio	, Inspection ⊠ le □, Undete KAMINER EXAMINER	Yes No (State) (State)
especially important.	TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF PRIMARY OF CONTRIBUTING OF Stree CAUSE OF DEATH. 21d. TIME (Month) (Day) (Year) (Hour) 12c. INJURY 21d. TIME (Month) (Day) (Year) (Hour) 21c. INJURY 22c. I hereby certify that I took charge of the resulted from: Natural causignature 23. BURIAL CREMATION DATE THEREOF NAM REMOVAL (Specify)	operation: ne, farm, factory, t, office bldg., etc., COCCURRED Not while at work emains described a	Above, held an A CHEF M CHEF M DEPUTY M. D. ASSISTAN	utopsy Homicic EDICAL E: MEDICAL IT MEDICA	, Inspection ⊠ le □, Undete KAMINER EXAMINER	Yes No (State) (State) (, Inquiry , and crmined cause DATE SIGNED (, 22-55
is especially important.	TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF STREET OF DEATH. 21a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING OF STREET OF DEATH. 21d. TIME (Month) (Day) (Year) (Hour) 21c. INJURY While at work OF INJURY 22. I hereby certify that I took charge of the refind that death resulted from: Natural causing Signature 23. BURIAL, CREMATION DATE THEREOF NAME REMOVAL (Specify)	ne, farm, factory, to office bldg., etc., offi	Above, held an A CHEF M CHEF M DEPUTY M. D. ASSISTAN	utopsy Homicion Homicion Homicion Homical Homi	, Inspection ⊠ le □, Undete KAMINER EXAMINER L EXAM.	Yes No (State) (State) (State) , Inquiry , and ermined cause . DATE SIGNED (S-22-(1) ounty) (State)

A15A-5-53

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct

VS. A15A - 5 - 53

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4786

The

CERTIFICATE OF DEATH Reg. Dist. No. 2/6

	2. USUAL RESIDENCE (HOME) OF DECEASED:			
county Montgomery Maryland	STATE Virginia COUNTY			
CITY (If outside corporate limits, write RURAL LENGTH OF STA OR and give nearest town)	CITY(If outside corporate limits, write RURAL and give no			
X TOWN Bethesda 17 days	Town Roanoke 83x	-0		
HOSPITAL OR The Clinical Center STREET ADDRESS Natl. Institutes of Health	STREET (If rural give location) ADDRESS 1916 Canterbury Road			
3. NAME OF (First) (Middle) DECEASED: (Type or Print) ROY Franklin	(Last) 4. DATE (Month) (Day) OF DEATH: May 22	(Year)		
5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, RACE: WIDOWED, DIVORCED,		DER 24 HRS		
10A. USUAL OCCUPATION (Give kind of work done during most of working life. OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): 12. CITIZEN COUNTRY	OF WHA		
even if retired): Sales mgr. Private industry	West Virginia U.S.A.			
13. FATHER S NAME:	14. MOTHER'S MAIDEN NAME:			
Ben Barnes	Laura Smitherman			
(Yes, no, or unk.) (If Yes, give war or dates of service) 18. Social Security No.	The medical record, The Clinical Cent	ter		
18. MEDICAL CERTIFICATION DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	The state of the s	L BETWEE		
IMMEDIATE CAUSE (A) Respirato	ory failure			
ANTECEDENT CAUSE (S)				
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Primary to the	tumor of left lung			
(C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING				
TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19a. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATI	ION 20. A	UTOPSY1		
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, for CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bld.	factory, 21c. WHERE DID (City or town) (County)	(State)		
(IF EITHER, NOTIFY MEDICAL EXAMINER) 21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURR OF INJURY While Not while	ZED 21F. HOW DID INJURY OCCUR?			
01 114301(1	T TOTAL MORE CO. 12 FF			
M. at work at work				
22. I hereby certify that I attended the deceased from Maj				
M. at work at work	at 8:25p M, from the causes and on the date stated all The Crinical Center	bove.		
22. I hereby certify that I attended the deceased from Majalive on May 22, 1955., and that death occurred a SIGNATURE 23. BURIAL, CREMATION, DATE THEREOF NAME OF CEME	at 8:25p M, from the causes and on the date stated al	bove.		
22. I hereby certify that I attended the deceased from May alive on May 22,, 1955., and that death occurred a SIGNATURE	The Clinical Center M. D. Natl. Institutes of Health TERRY OR CREMATORY LOCATION (City, town, or county)	bove. D 55 (State		



BUREAU V. S.

A15-10-53

VS.

		T OF HEALTH—BALTIMORE, 18()475	8 2.16	
	Item 1, Film G181, 5/11/55 CERTIFICATI		20/0	
ly.	1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:		
legibly.	county Montgomery MARYLAND	STATE Md. COUNTY Montgomer	-	
d le	CITY (If outside corporate limits, write RURAL LENGTH OF STAY on and give nearest town)	CITY(If outside corporate limits, write RURAL and give no	earest town)	
and	Town Chevy Chase	Town Chevy Chase	56	
clearly	HOSPITAL OR INSTITUTION OR STREET ADDRESS 6412 Western Ave.	STREET (If rural give location) ADDRESS 6412 Western Avenue		
ath	DECEASED: Katie Ba	uer 4. DATE (Month) (Day) OF DEATH: May 5,	(Year) 1955	
of	THE PROPERTY OF THE PROPERTY O	.18,1869 9. AGE last birthday IF UNDER 1 YEAR IF UN Months Days Hou	irs Min.	
causes	104 LISUAL OCCUPATION (Give kind of 108, KIND OF BUSINESS	11. BIRTHPLACE (State or foreign country): 12. CITIZEN COUNTR		
0.5	work done during most of working life. even if retired): At Home OR INDUSTRY:	Baltimore, Maryland		
the	13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:		
	Nicholas Steinmacher	Margaret Anna Horner		
wri	(Yes, no, or unk.) (If Yes, give war or dates of service)	Paul Edgar Bauer - Son 7502 Vale Street, Chevy Char	se Md	
	18. MEDICAL CERTIFICAT	TION	L BETWEEN	
UNFADING sicians: plea	I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	UNSEL	AND DEATH	
ALL IS:	IMMEDIATE CAUSE (A) INEM	110-	4	
N iar	ANTECEDENT CAUSE (S)	Part Deach		
0.7	DISEASES OR CONDITIONS, IF ANY. GIVING RISE TO THE ABOVE CAUSE DUE TO	solve (andro Oescular		
→	STATING UNDERLYING CAUSE LAST. (C)	Real House 10	p	
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE			
por	DISEASE OR CONDITION CAUSING DEATH. 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATIO	N Loo	HZOCOVA	
7	0	YES	nen nen	
RITE PL	OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg. (IF EITHER, NOTIFY MEDICAL EXAMINER)		(State)	
> ,0	21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while at work at work	D 21F. HOW DID INJURY OCCUR?		
ge i	22. I hereby certify that I attended the deceased from	7 , 1940, to 5 5 , 1953, that I last saw th	e deceased	
SE TYPE OR correct age is	alive on 5.5., and that death occurred at	ADDRESS Rd 170 DATE SIGNED ADDRESS Rd 170 5 5	above.	
E	23, BURIAL, CREMATION, DATE THEREOF NAME OF CEMET	TERY OR CREMATORY LOCATION (City, town, or county)		
PLEAS	Burial 5/7/55 Cedar Hil	.1 Mausoleum Prince Georges Co		
PL	DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR 5 6 5 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	The S. N. Hure Co 2901 1908	rst.,	

THE PROPERTY OF THE PARTY

BUREAU V. S.

2301 6 YAM

BECEINE

STATE AND ADDRESS OF LANSAGERS

ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: CITY (If outside corporate limits write RURAL and give nearest town) (If rural, give location) (Day) (Year) 19 9. AGE last birthday; IF UNDER 1 YEAR | IF UNDER 24 HRS Days Months Hours 12. CITIZEN OF WHAT 11. BIRTHPLACE (State or foreign country): COUNTRY? INTERVAL BETWEEN 20. AUTOPSY? Yes No Z (State) DATE SIGNED

BUREAU V. S.

SS61 PS YAM

BECEINED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

(13762 Bist.

ADDRESS

(State)

LOCATION (City, town, or county)

Bethesua

TEDICAL	EXAMINER'S	CERTIFICATE	OF	DEATH	No
LEDICAL		CEMILITICALL	OT.	DIALL	No.

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:
county Montgomery maryland	STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL OR and give nearest town) CITY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town OR ROCKVILLE
HOSPITAL OR INSTITUTION OR 507 Wood ston Rd.	STREET ADDRESS 507 Wood Ston Rd.
3. NAME OF (First) (Middle) DECEASED: (Type or Print) JEFFERSON C. BEEK	(Last) 4. DATE (Month) (Day) (Year) OF DEATH DEATH 2. 195519
Male White WIDOWED, DIVORCED, 3-25	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Mechanic Self Lmp.	11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WILL COUNTRY? II. Carolina
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Thomas J. Beeker	Ann Leonard
(Yes, no, or unk.) (If Yes, give war or dates of	17. INFORMANT & ADDRESS: Cleo L. Beeker- Item ## 2
18. MEDICA	AL CERTIFICATION
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:	INTERVAL BETWEE ONSET AND DEAT SUBJECT
Antecedent cause(s) Diseases or conditions, if any, (b)	deark
giving rise to the above cause DUE TO stating underlying cause last (c)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes □ No Ø
21a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING 21b. PLACE (Home, farm, factory, OF street, office bldg., etc. INJURY	
21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED While at Not while INJURY M. work \(\begin{array}{cccccccccccccccccccccccccccccccccccc	21f. HOW DID INJURY OCCUR?
	dent _, Suicide _, Homicide _, Undetermined cause _ CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAMINER

NAME OF CEMETERY OR CREMATORY

Arlington

PLEASE WRITE PLAINLY, WITH UNFADING INK. age is especially important. Physicians: please

23. BURIAL, CREMATION.
REMOVAL (Specify)

DATE REC'D BY LOCAL REG. 5/4/5-5

DATE THEREOF

REGISTRAR'S SIGNATURE

MARGIN RESERVED FOR BINDING

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SECEIVED NAY 6 1955

BUREAU V. S.

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ratific.	-	400	-

1	The	4100	ORDATEIC AND	THE DEADE	D D1 .	2 1/6
			CERTIFICATI	OF DEATH	Reg. Dist.	No. 21.0
	ull ly.	1. PLACE OF DEATH:		2. USUAL RESIDENCE (H	OME) OF DECEASED	1: 1
	ref	COUNTY MONTGOMETY	MARYLAND	STATE Maryani	0001111 7 170	Tgomery
	d le	CITY (If outside corporate limits, write OR and give nearest town)	RURAL LENGTH OF STAY	OR CITY(If outside corporate	limits, write RURAL ar	nd give nearest toyn)
	tior	X TOWN Bethesda	2 hours	TOWN SIIVEY	Spring	56
20	rly	HOSPITAL OR		STREET ADDRESS	If yural give location)	+ 1
M	information carefully clearly and legibly.	14STREET ADDRESS Suburba	2 h	25/0/	imperly :	5/
	-	3. NAME OF (First)	t. t.	Rolt	F A	Day) (Year)
	m o	(Type or Print) 5. SEX: 6. COLOR OR 7. SINGLE	E. MARRIED. 8. DATE		st birthday IF UNDER I YE	EAR IF UNDER 24 HRS.
	item of of death	Male RACE: WIDOV (Specify	VED. DIVORCED. A	12 1900 5-1		ays Hours Min.
		IOA. USUAL OCCUPATION (Give kind of 1	OB. KIND OF BUSINESS	11. BIRTHPLACE (State or	foreign/country): 12.	CITIZEN OF WHAT
51	every	work done during most of working life. even if retired) foreman	Telephone Co	District of	1 (alumbia	COUNTRY
FOR BINDIN	upply the c	13. FATHER'S NAME:	10 ·	14. MOTHER'S MAIDEN	AME:	,
Z	Supply te the	Kopept E.	13014	SATHERI	NEALOXA	DAN
S B	. E	18. WAS DECEASED EVER IN U.S. ARMED FORCEST		17. INFORMANT & ADDRE	95: 1 3059	9 Oliver M
10		(Yes, no, or unk.) (If Yes, give war or dates of service)		J. William D.	elt. IUA	Shington
			18. MEDICAL CERTIFICAT	ION		INTERVAL BETWEEN
VE	ADING s: plea	I DISEASES OR CONDITIONS DIRECTL	T LEADING TO DEATH	17 1	0 1	ONSET AND DEATH
ER	AI ns:	IMMEDIATE CAUSE	(A) levelved	Genomety	- liculia	20042
RESERVED	UNFA	ANTECEDENT CAUSE (S)	DUE TO	0. 0	1	
		DISEASES OR CONDITIONS, IF ANY,	(B) Wally	selleris de	ilzan c	yrs.
GII	WITH it. Phys	STATING UNDERLYING CAUSE LAST.	when	of Grading	0	U
MARGIN	W int.	II OTHER SIGNIFICANT CONDITIONS	(C)	1	\	
M	AINLY, Wimportant.	TO THE DEATH BUT NOT RELATED TO	THE C.	Lovis		
	INI		R FINDINGS OF CHERATION	V		20. AUTOPSY?
	4	D NW				YES NO NO
		OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE (Home, farm, fact OF INJURY street, office bldg.,	etc. INJURY OCCUR?	y or town) (County	(State)
1	RITE specia	(IF EITHER, NOTIFY MEDICAL EXAMINER) 21D. TIME (Month) (Day) (Year) (Hour)	21E INJURY OCCURRED	21F. HOW DID INJURY	OCCUR?	
1	70	OF INJURY M.	While at work at work			
	- June 1	22. I hereby certify that I attended	the deceased from 3 3	15 , 19 , to 4 12 57	, 19, that I last	saw the deceased
23	20	alive on 4 12 5 _ 19 , a	nd that death occurred at	10:03 M, from the cause	s and on the date :	stated above.
8	TYPE rect ag	SIGNATURE	A . A	ADDRESS	DAT	TE SIGNED
- 10		Lamad	alley M	. D. Carsing M	ATION (City, town, on	county) (State)
ro 1	A	23. BURIAL, CREMATION, DATE THER REMOVAL (SPECIFY)		ational Cemetery	Prince Geo. C	
A1	PLE	Burial 5/16/5	R'S SIGNATURE	24. FUNERAL DIRECTO		
Š	Д	DATE REC'D BY LOCAL REGISTRAF	M. Harris Land	Ylaunes & Tu		GADDRESS GA. AVe.
		- I have	" I wow work	Curry Ro sum	phuly Silve	er Spring, Md.



BUREAU V. S.

MARGIN RESERVED FOR BINDING

please write the causes of death clearly and legibly.

especially important. Physicians:

correct age is

WRITE PLAINLY, WITH

OR

TYPE

PLEASE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04761 1759

CERTIFICATE O	\mathbf{F}	ΗСΑ	WHE
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2 0 0 CERTIFICATI	E OF DEATH Reg. Dist	. No
I. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASE	D:
COUNTY MARYLAND CITY (If ostside corporate limits, write BURAL LENGTH OF STAY OR and vive nearest down) (in this place)	STATE COUNTY CITYIII outside corporate limits, write RURAL OR	and give nearest town)
11 TOWN Laconia 1000	TOWN Organderia	83x-3
HOSPITAL OR INSTITUTION OR STREET ADDRESS OF The ladelphia WE	STREET (If rural give location) ADDRESS 609 Hernelsens Jan	Wers I
3. NAME OF DECEASED: (Widdle) (Middle) (Type or Print) Evelyn 1. Deules	OF 7	Day) (Year)
5. SEX: 6. COLOR OR 7. SINGLE, MARRIED. 8. DATE WIDOWED. DIVORCED. DEC 3	OF BIRTH: 9. AGE last birthday IF UNDER 1	YEAR IF UNDER 24 HRS. Days Hours Min.
work done during post of working the or INDUSTRY: even if retired):	11. BIRTHPLACE (State of foreign country): 12.	CITIZEN OF WHAT COUNTRY?
Mr. Henton	May of Worthis	glow
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unk.) (If Yes, give war or dates of service)	Miss Margie Micholson	Hentily Veners
18. MEDICAL CERTIFICAT I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	ION	INTERVAL BETWEEN
1150.0		ONSET AND DEATH
IMMEDIATE CAUSE (A) CIRCLO	Decompensation	3-4-910
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, (B)	selevous	7
STATING UNDERLYING CAUSE LAST. (C) Browle	sopnermoni	6-7 Blays
TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	let	7.
19a. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION	N .	20. AUTOPSY? YES NO P
OR CONTRIBUTING \(\) CAUSE OF DEATH OF INJURY street, office bldg., (IF EITHER, NOTIFY MEDICAL EXAMINER)		ty) (State)
21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from	, 1955, to 23 may, 1953, that I last	saw the deceased
alive on 22 may . 1955, and that death occurred at SIGNATURE	7.727M, from the causes and on the date DA.	stated above. re signed
	. o. Solver Spring, may	123/55
Kemoval (Specify) 423-55 Demain	ery or crematory Location (City, town, or	11-00
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	1 24. FUNERAL DIRECTOR	ADDRESS

OYER

Emily Virginia Benton Burial May 24, 1955 Mt. Comfort Geneley Chiefay City, Va Funeral Director

Stan Demain & Sono

alejandria Va

BUREAU V. S.

2261 3S YAM

BECEINED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04762 CERTIFICATE OF DEATH

	OBRITTORI	Reg. Dist.	No
	1. PLACE OF DEATH;	2. USUAL RESIDENCE (HOME) OF DECEASED:	
ly.	county Montgomery MARYLAND	STATE Maryland COUNT	Y Mort
and legibly	CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) (in this place)	OR	d give nearest town)
d 16	X TOWN Chevy Chase 38 yrs	TOWN Chevy Chase STREET (If rural give location)	X
	INSTITUTION OR STREET ADDRESS # 109 Quincy Street	ADDRESS# 109 Quincy Street	
clearly	3. NAME OF (First) (Middle) DECCASED: MARGARET ALICIA BIN	(Last) 4. DATE (Month) (DRy)	(Year)
	(Type of Frinc)	OF BIRTH: 9. AGE iast birthday: If UNDER 1 YE	19 AR IP UNDER 24 HRS.
death	Female White Widowed, Divorced, (Specify): widowed 7-4-	76 yrs. 9 28	Hours Min.
Jo	10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): HOBSEWIFE	R 11. BIRTHPLACE (State or foreign country): 12. C.	TIZEN OF WHAT DUNTRY? SA
causes	13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	
ca	John McDonald	Ellen Keohane	
the	15 WAS DECEASED EVER IN U.S. ARMED FORCES! 16. SOCIAL SECURITY No.: 17	7. INFORMANT & ADDRESS:	
	service)	Julia A McDonald, 5607 Brook	ville,Rd
write	18. MEDICAL CERTIFICAT		Interval Between
Se	1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	1 Hounty 2	Onset And Death
please	Immediate cause (a)		<i>C</i> •
	Antecedent causes (s)	rof Heventog? Solervis	6-1100
rnysicians:	Diseases or conditions, if any, (b)		••••
SIC	(c)		
	11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
ant	198. DATE OF OPERATION: 196. MAJOR FINDINGS OF OPERATION		20. AUTOPSY ?
ort	21. ACCIDENT (Specify) PLACE (Home, form, factory, street	CITY OR TOWN) (COUNTY) (ST	Yes No
important.	SUICIDE OF office bldg., etc.) HOMICIDE INJURY	Chevy Elon hear	yave
especially	TIME (Month) (Day) (Year) (Hour) INJURY OCCURED While at Not While	HOW DID INJURY OCCUR?	-
eci	22. I hereby certify that I attended the deceased from	1 105 5 to 1200 2 1955 That I last s	aw the deceased
esp	alive on 2 , 1955, and that death occurred at		tated above.
Ω.	SIGNATURE (Degree or title)	ADDRESS DA	PE SIGNED
g.e	extrely, ma	ERY OR CREMATORY LOCATION (City, town, or cou	ntt) (State)
00	23. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) 5-5-1955 Arlington	National Cem Ft. Myer, V2.	(100000)
11	DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR 1756 Pa	ADURESSN . W.
	REGISTRARY 4/55 Bessie M. Thompson	Jos. Gawler's Sonswashingto	n, D. C.

NECELVE 6 1955

Elect Com BUREAU. V. S.

Lalenoni

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

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AlbA	PI.E
A	P

MEDICAL	EXAMINER'S	CERT	TIFICATE	OF	DEAT	H No. 218
I. PLACE OF DEATH:			2. USUAL RESIDEN	CE (HOME)	OF DECEASED	:
COUNTY MANY	MAR.	YLAND	STATE 71.10.0	cfc co.	UNTY DEL	nely.
CITY (If outside corporat OR and give nearest to TOWN		TH OF STAY this place)	CITY (If outside OR TOWN	/ /		L and give nearest town
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS		rural, give loca	tion) 1728
3. NAME OF DECEASED: (Type or Print)	First) (Middle)	12:	(Last)	4. DATE OF DEATH	(Month)	(Day) (Year) 1955
Sex: 6. COLOR RACE:	WIDOWED, DIVORO	ED. Fred 1	16-1875	80	yrs. Month	es Days Hours Min
10a. USUAL OCCUPATION work done during mos even if retired)	st of work life. INDUSTR	BUSINESS OR Y:	Cerstran	e for	oreign country)	12. CITIZEN OF WILL COUNTRY?
13. FATHER'S NAME:			14. MOTHER'S MAI	DEN NAME:		7
milmo			mulosso	wo		
(Yes, no, or unk.) (If Yes, giservice)		CURITY No.: 1	7. INFORMANT & A	DDRESS:	Inford Ol	ochobus n
1		18. MEDICAL	L CERTIFICATION			INTERVAL BETWE
111	ONS DIRECTLY LEADING TO D	EATH:	1		•	ONSET AND DEA
1465 X	in delt 1	nelum	an This	sufra		Few men
Immediate cause	DUE TO	and the second second				0
Antecedent cause(s						
Diseases or conditions, i	if any, (b)	*************		**************	***************************************	***************************************
giving rise to the above stating underlying cause	an last					
II. OTHER SIGNIFICANT OF THE DEATH BUT	CONDITIONS CONTRIBUTING T NOT RELATED TO THE	Stilet	alasis	pr l	11-0	?
	ON CAUSING DEATH	and last. Peri Peri and a contract of the cont			7	20. AUTOPSY?
					1	Yes X No
21a. EXTERNAL CAUSE W PRIMARY or CONTRIB CAUSE OF DEATH.	VAS DITING DE STREET, CONTROL OF	farm, factory, office bldg., etc.,	21c. (City or tow	m)	(County)	(State)
21d. TIME (Month) (Day) OF INJURY		Not while at work	21f. HOW DID I	NJURY OCC	UR?	
22. I hereby certify th	at I took charge of the rem	nains describ	ed above, held ar	Autopsy	, Inspection	n □, Inquiry □, ε
	sulted from: Natural causes		ent □, Suicide [CHIEF	, Homie	cide [], Un EXAMINER	
Trank	4. I prosehout		M. D. ASSIS	TANT MEDICAL	CAL EXAM.	B 2-1-22
23. BURIAL, CREMATION, REMOVAL (Specify):	45-4-55 Af	OF CEMETERS	OR CREMATORY	mos	ON (City, town,	or county) (State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	rke.	Treest 6	Mari	Jur La	The Abusy

PECEUVED V. S. BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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4	1	ч	- 5

4791 CF	ERTIFICATI	E OF DEAT	NH F	Reg. Dist. N	0.	9
1. PLACE OF DEATH:		2. USUAL RESIDE	NCE (HOME) OF	DECEASED:		
COUNTY Montgomery	MARYLAND	state Mar	yland county	Prince	Georg	ge
CITY (If outside corporate limits, write RURA			corporate limits, write	RURAL and	give neare	st town
Y OR and give nearest town) Bethesda	36 days		densburg		6-33	- 2
50 STREET ADDRESS National Instit		STREET ADDRESS 4111	(If rural gives 54th St.	re location)		/
	Middle)	(Last)	4. DATE (Mon	th) (Day)) (Ye	ar)
DECEASED: (Type or Print) Theresa	P.	Blaine	OF DEATH: M	ay 10	19	
5. SEX: 6. COLOR OR 7. SINGLE, MA WIDOWED, I (Specify): Mg	DIVORCED	of BIRTH: 9	47 yrs.	Months Days	Hours	24 HRS. Mln.
OA. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife	IND OF BUSINESS	New York	State or foreign count	CO	IZEN OF UNTRY?	WHAT
13. FATHER'S NAME:	100	14. MOTHER'S MA	IDEN NAME:	1 0.		
Henry S. Preston		Josephi	ne Larson			
	SOCIAL SECURITY NO.	17. INFORMANT 8				
(Yes, no, or unk.) (If Yes, give war or dates of service)		The medical	record, The	Clinical	Cente	r
18.	MEDICAL CERTIFICAT	TION		IN	TERVAL B	FTWEEN
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C.)	то	(a mureum				
II OTHER SIGNIFICANT CONDITIONS CONTR TO THE DEATH BUT NOT RELATED TO THE	IBUTING					
DISEASE OR CONDITION CAUSING DEATH		N			20 11174	
None d		DECAME A			ES TO	NO
OR CONTRIBUTING CAUSE OF DEATH OF INJ	LACE (Home, farm, fac JURY street, office bldg.,	tory, 21c. WHERE D	(City or town)	(County)	(St	ate)
OF INJURY Wh	INJURY OCCURRED	21F. HOW DID II	NJURY OCCUR?	3.1		
22. I hereby certify that I attended the dealive on May 10, 1955, and the SIGNATURE 23. BURIAL, CREMATION, PATE THEREOF REMOVAL (SPECIFY)	at death occurred at	8:35AM, from th	e causes and on the nical Center institutes of	the date star DATE S Health	ted abov	e.
DATE REC'D BY LOCAL REGISTRAR'S SIG	Jes Wash	Mem. Park 24. FUNERAL D	Prince for	/3	DDRESS	1D.
REGISTRAR 5/12/55 Desse My	Homkson	WW	· Chamber	CO.14.	00 Chap	in 24.

VS. A15-

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK.

MARGIN RESERVED FOR BINDING

Supply every item of information carefully. The M

RECEIVED MAY 16 1955

BUREAU V. S.

CITY(If outside corporate limits, write RURAL and give nearest town) (If rural give location) 4. DATE (Month) (Day) (Year) 18 May 19 DEATH: 9. AGE last birthday IF UNDER I YEAR IF UNDER 24 HRS Months 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF COUNTRY? U.S.A. The medical record, The Clinical Center INTERVAL BETWEEN ONSET AND DEATH 20. AUTOPSY? Patent ductus arteriosus with reversal of flow and YES X dilatation of atherosclerotic pulmonary artery. 21A. ACCIDENT WAS UNDERLYING | 21B. PLACE (Home, farm, factory. 2fc. WHERE DID (City or town) (County) (State) INJURY OCCUR? 21F. HOW DID INJURY OCCUR? DATE SIGNED May 18,1955 county)

Reg. Dist. No. 2/6

OF INJURY 20 OR

PLEASE

22. I hereby certify that I attended the deceased from Apr 27, 1955, to May 18, 19.55 that I last saw the deceased alive on May 18, 19.55, and that death occurred at 3:20P M, from the causes and on the date stated above.

at work

OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., etc.

SIGNATURE Clinical The Clinical National Insti M. D.

23, BURIAL, CREMATION, REMOVAL, (SPECIFY)

21E INJURY OCCURRED

Not while

at work

DATE REC'D BY LOCAL REGISTRAR

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21D. TIME (Month) (Day) (Year) (Hour)

BUREAU V. &

SSEL ES YAM

RECEIVED

- 10 - 53 VS. A15-

	OF DEATH Reg. Dist. No. 2/6
	. USUAL RESIDENCE (HOME) OF DECEASED:
county Montgomery MARYLAND	STATE Maryland county Montgomery
CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) (in this place)	CITY(If outside corporate limits, write RURAL and give nearest town) OR
X TOWN Rural-Potomac	TOWN Rural-Potomac X
HOSPITAL OR INSTITUTION OR	STREET (If rural give location) ADDRESS
STREET ADDRESS	Rt. #3 Box126 Bethesda.Md.
3. NAME OF (First) (Middle) (Las	
DECEASED: (Type or Print) ALICE EMMA BONIFA	NT OF May 19, 19 55
5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE OF RACE: WIDOWED, DIVORCED,	
Female White (Specify): 12-25-63	3 91 yrs. 4 24 Hours Min.
OA. USUAL OCCUPATION (Give kind of 108. KIND OF BUSINESS 11	. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT
	Montg. Co., Maryland US
	4. MOTHER'S MAIDEN NAME:
T- D : 0	Laura Craigen
	7. INFORMANT & ADDRESS:
(Yes, no, or unk.) (If Yes, give war or dates	Lorence Bonifant-Item # 2
18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	ONSET AND DEATH
IMMEDIATE CAUSE (A)	· Pholographical a - 1 psy
ANTECEDENT CAUSE (S)	- bul proxin - IDSY - bul interiorderes 10/con
DISEASES OR CONDITIONS, IF ANY. (B)	bao 14 h 1 the ose teams 10/000
GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST.	
(C)	
TO THE DEATH BUT NOT RELATED TO THE	1 1 1 11 1
DISEASE OR CONDITION CAUSING DEATH.	(9 /7 y per/kuphic /3K/ hK//)
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	YES NO.
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, factory, OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
(IF EITHER, NOTIFY MEDICAL EXAMINER)	21F. HOW DID INJURY OCCUR?
OF INJURY While Not while	ZIF. HOW DID INJURY OCCURY
M. at work at work	toto the st
22. I hereby certify that I attended the deceased from 4.6	, 1944 to 5, 1922, that I last saw the deceased
	M, from the causes and on the date stated above.
SIGNATURE DE MODEL	ADDRESS DATE SIGNED
M. D.	OR CREMATORY LOCATION (City, town, or county) (State)
	OR CREMATORY LOCATION (City, town, or county) (State)
23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY	petomac Manuland
Burial Specify 5-21-55 Potomac Ceme	
REMOVAL (SPECIFY)	Potomac, Maryland ADDRESS ADDRESS ADDRESS ADDRESS ADDRESS ADDRESS ADDRESS ADDRESS ADDRESS

BUREAU V. S.
MAY 26 1955

The correct age

4794

2411 N. Charles Street, Baltimore CERTIFICATE OF DEATH

Reg. Dist. No. 2/3

I. PLACE OF DEATH-			2. USUAL RESIDENCE	HOME) OF DECI	ASED		
COUNTY Montgo	mery	MARYLAND	STATE Maryla	nd	COUNTY	Montgo	mer
CITY (Il outside corpora	te limits, write RUR.	AL and LENGTH OF STAY	CITY (If outside corpo	rate limits, write R	URAL and giv	e nearest town	a)
TOWN ROCKY	ville - rural	Life (in this place)	TOWN Rocky	ille - rura			X
HOSPITAL OR			STREET	(If rural, gi	ve location)		1
INSTITUTION OR STREET ADDRESS I	Boswell Lar	ne - rural -RD#2	ADDRESS Bosy	vell Lane	- R. F. I	D. #2	
3. NAME OF DECRASED	(First)	(Middle)	(Last)	4. DATE	(Month)	(Day)	(Year)
(Type or Print) Jar	nes	M.	BOSWELL, Sr.	OF DEATH	May	28	1955
	OLOR OR RACE	7. SINGLE, MARRIED,	8. DATE OF BIRTH	9. AGE last birth	day II under	I year II und	er 24 hrs.
Male	White	WIDOWED DIVORCED, (Specify) Married	3/15/1882	73	rs. Months	Pays Hour	Min.
10a. USUAL OCCUPATION		10h Kram on Brighings on	11. BIRTHPLACE (State	or foreign country)	12	CITIZEN OF	WHAT
done during most of working	(nie, even it retired)	INDUSTRY Self-empl.	Maryland			COUNTRY	SA
13. FATHER'S NAME			14. MOTHER'S MAIDE	NAME			
Char	les E. Bos	well	Mary catheri	ne Melbro	ok		
15. WAS DECRASED EVER IN	U.S. ARMED FORCES	? 16. SOCIAL SECURITY No.	17. INFORMANT AND	ADDRESS			
(Yes, no, or unknown) (If ye	es, give war or detes ('e)	None	Martha C. Bo	swell- Sar	ne Item	#2	
		18. MEDICAL CE	RTIFICATION				
I. DISEASES OR CONDIT	TIONS DIRECTLY	LEADING TO MEATH	11			INTERVAL BI	
T. DISEASIES ON CONDI	TONS DINGCISI	THE TOP AND THE	-// / .			ONSET AND	DEATH
Immediate cau	ge (a)	(mons	1 true			24	LAND
			()			0	
Antecedent car Diseases or conditi							
giving rise to the a	bove cause						
stating the underly							
II. OTHER SIGNIFICANT	(c)					10	
Conditions contributing to related to the disease or c	o the death but not	h.					
19a. DATE OF OPERATIO	ON 19b. MAJOR E	FINDINGS OF OPERATION				20. AUTOP	SYI
0						Yes 🗆	No 🗆
21. ACCIDENT (Sp SUICIDE HOMICIDE	Decify) PLACOF	CE (Home, farm, factory, street, office bidg., etc.)	(CITY OR	TOWN)	(COUNTY)	(STAT)	
TIME (Month) (Day		INJURY OCCURRED	HOW DID INJURY OC	CUR?			
OF INJURY	m.	While at Not While Work At work					
1.49 0.16.1	ш, 1	y -	1				
22. I hereby certify th	at I attended the	deceased from	19.54, to 08 M	LAS 19 55 t	at I last an	w the dece	nsed
- 77 h							
alive on.	4.4, 19. A.L. an	d that death occurred at	ADDRESS	causes and on	the date sta	ated above.	
SIGNATURE	11/11	1 Degree of time A	ADDICESS .) 1	70%	DATE SIG	NED
1/1/) Mun	Muy 10	() dal	truel 10 /k	Kel	10 M	AG 53	
23. BURIAL, CREMATION	DATE THERE	NAME OF CEMETE	RY OR CREMATORY	LOCATION (City,	town, or count	y) (St	ate)
urial (Specify)	5/30/195	5 Darnestow		Montgome		Maryla	and
DATE REC'D BY LOCA	L REGISTRAR'S		24. FUNERAL DIRECTO	OR / /		ADDRESS	
REG. 5/31/50	James 10	It. Kuzlos b	Roberts a. V		01 BE	thesda	Md

VS. A15

DECENALED

BUREAU V. S.

Sati I Hat

2411 N. Charles Street, Baltimore

	4795	CERTIFICAT	TE OF DEAT	H 1	Reg. Dist. No	214
I. PLACE OF DEAT	IH.		2. USUAL RESIDENCE (I	HOME) OF DEC	EASED.	
COUNTY	taonery	MARYLAND	STATE STATE)	COUNTY	onen
CITY (If outside	corporate limits, write RUR	AL and LENGTH OF STAY	CITY (If owtside corpora	nte limits, write I	RURAL and giv	e pearest fown)
X TOWN Prost	nerville	(in this place)	TOWN RFD	Laurel	Mary &	
HOSPITAL TO	USAITTE	11 01	STREET BULLONS	VIII rural,	rive location)	7
STREET ADDRE	DR /	Street.	ADDRESS Doras		9	
3. NAME OF DECEASED	(First)	(Middle)	(Last)	4. DATE	(Month)	(Day) (Year)
(Type or Print)	SIMON	FRANKLIN	BOWERSETT	DEATH	MAY	9 195.
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birt		1 year If under 24 hr Days Hours Min
done during most of	PATION (Give kind of work working life, evon if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State of		12	COUNTRY'S
13. FATHER'S NAI	ME,	7	14. MOTHER'S MAIDEN	NAME	, ,	2311.
Char	les Byrd	Bowersett	mary a	ligo Ra	men	
15. WAS DECRASED I	EVER IN U.S. ALMED FORCE	S? 16. SOCIAL SECURITY NO.	17. INFORMANT AND	ADDRESS	7	
(Yes, no, or unknown)	(If yes, give war or dates service)	01213-12-1786	Son-Charles 13	oversett	-same a	ddress
		18. MEDICAL CE	ERTIFICATION			
I. DISEASES OR C	ONDITIONS DIRECTLY					INTERVAL BETWEEN
44		DEMONITO TO DEMAN	,			ONSET AND DEATH
Immedia		wremed syn	drone		•••	2 weeks
Diseases or giving rise	ent cause(s) conditions, if any, (b) to the above cause underlying cause last	kidney fail	luce	7-00-4-0-4-0-1-1-1-1-1-1-1-1-1-1-1-1-1-1-	**************************************	1 year
acating the	(c)	arleren les				
II. OTHER SIGNIE	ICANT CONDITIONS	or yours so ways	3			1
Conditions contrib	uting to the death but not	A.L.				
	ase or condition causing dea	FINDINGS OF OPERATION				1 20 ATTOODERS
Division of 011	1	The state of the s				20. AUTOPSY?
21. ACCIDENT	(Specify) PLA	CE (Home, farm, factory, street,	(CITY OR T	MAIL	(COUNTY)	Yes No
SUICIDE HOMICIDE	OF INJ	office bidg., etc.)		-	(COUNTY)	(STATE)
TIME (Month)	(Day) (Year) (Hour)	While at Not While	HOW DID INJURY OC	CUR?		
INJURY	m,	Work At work				
alive on 9		de deceased from January and that death occurred at	10 P. m., from the	/		
SIGNATURE	1 0//	(Degree or title)	ADDRESS	1 /	. 5	DATE SIGNED
John	- K Mull	mp 9	tor main s	+ Laure	1 mayle	en 9 May 51
23. BURIAL, CREM REMOVAL (Spe BUTTAL	elly) 5/12/55	Geo. Wash. M	em. Cemetery		leo. Coun	ity, Mc.
DATE REC'D BY REG.	LOCAL REGISTRAR'S	SIGNATURE	24, FUNERAL DIRECTO	R	434 Ga.	ADDRESS
may /31.	55 +1200	eed Totter	VIMULIAN & THE	nhunes o	10.2	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

The correct age

VS. A15

DECEIVED MAY 17 1955

BUREAU V. S.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLAINLY, WITH UNFADING INK.

Supply every item of information carefully. The

VS.

PLEASE TYPE OR WRITE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

)	7	2
Reg.	Dist.	No	1	1	כ

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASE	ED:
COUNTY MONT 90 METY MARYLAND	STATE DC COUNTY	
CITY (If outside corporate limit, write RURAL) LENGTH OF STAY		and give nearest town
OR and give nearest town) (in this place)	OR / · /	100
Town Takoma Ports 9 days	Town washington	47x.5
HOSPITAL OR INSTITUTION OR	STREET ADDRESS	1)
Street Address Washington Sant Hosp.	1206 Hemlock St.	xw. V
3. NAME OF (First) (Middle)	(Last) 4. DATE (Month) OF	(Day) (Year)
(Type or Print) WILLIAM Franklin C	Prandt DEATH: 5" -	5- 1953-
5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE RACE: WIDOWED, DIVORCED.		YEAR IF UNDER 24 HRE.
M RACE: WIDOWED, DIVORCED, (Specify): Morried 7-	31-92 62 yrs. Months	Days Hours Min.
10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS	11. BIRTHPLACE (State or foreign country): 12	. CITIZEN OF WHAT
work done during most of working life. even if retired):		COUNTRY?
Salesman ITTEN TOUT Sales 4361		uso.
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	
Simon Brandt	Ella Conkle	
15. WAS DECEASED EVER IN U.S. ARMED FORCEST 16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:	
(Yes, no, or unk.) (If Yes, give war or dates of service)	Hosp. Records	
18. MEDICAL CERTIFICAT		INTERVAL BETWEEN
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		ONSET AND DEATH
420.1		1/1/-2
TIMMEDIATE CAUSE (A) Nuplure of X	least and Gemo porceardium	9/5/57
ANTECEDENT CAUSE (S) DUE TO		11/1
DISEASES OR CONDITIONS, IF ANY. (B) Man cardial	1 Arcaretion	12/1/65
GIVING RISE TO THE ABOVE CAUSE DUE TO	31/2001	7/
STATING UNDERLYING CAUSE LAST.	\mathcal{O}	
(C) OTOMOTH	Crelusion	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE		12/2/2010
DISEASE OR CONDITION CAUSING DEATH. Ongestiv	e Heart Failure	
194. DATE OF OPERATION: 198. MAJOR FINDINGS OF OPERATIO	N	20. AUTOPSY?
		YES NO
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fac OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., (IF EITHER, NOTIFY MEDICAL EXAMINER)	ctory. 21c. WHERE DID (City or town) (Cou	nty) (State)
21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED	D 2/F. HOW DID INJURY OCCUR?	
OF INJURY M. While Not while at work at work	111 =-	
22. I hereby certify that I attended the deceased from	.7., 1953, to 5/3/, 19 3, that I las	st saw the decease
alive on 5/2/, 1987, and that death occurred at	7:15 PM, from the causes and on the date	stated Ahove
SIGNATURE DE SIGNATURE		ATE SIGNED
23- BURIAL CREMATION DATE THEREOF NAME OF CEMET	ERY OR CREMATORY LOCATION (City, town,	or county)
23 BURIAL, CREMATION, BATE THEREOF NAME OF CEMET	TERY OR CREMATORY LOCATION (City, town,	or county) (State
count / soul 2	Canton.	MA
PATE REC'D BY LOCAL REGISTRATUS STENATURE	24. PONERAL PIRECTOR	ADDRESS /
REGISTRAR / CC)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20-11/01

3791 8 YAM

BUREAU V. S.

AL SECRETARIA - THE AREA TO SAME AND ARREST BALLETINGS IN

The correct age

4709

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

04770

eg. Dist. No. 214

		The second secon				
1. PLACE OF DEAT	n. ontgomery	MARYLAND	2. USUAL RESIDENCE STATE D.C.	(HOME) OF DECEA	COUNTY	
CITY (If outside c	orporate limits, write RUR. 1Ver Spring		CITY (If outside corp OR TOWN Washi	orate limits, write RU ngton	RAL and give	nearest town)
TIOCOTTAL OD	Rs12,304 Dewey	Road	STREET ADDRESS 272	7 N St., S		
3. NAME OF DECEASED (Type or Print)	(First) The odore	(Middle)	(Last) roderick, Sr.	OF DEATH M	(Month) ay 27,	(Day) (Year) 19 5 ⁴
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct. 29, 1867	87 y	m. Months	year If under 24 hrs. Hours Min.
done during most of	ATION (Give kind of work rorking life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	New Orles	ins, La.		CITIZEN OF WHAT
13. FATHER'S NAM Pat (I	e Daniel) Broderi	ck	,	ine Engel		
15. WAS DECRASED E (Yes, no, or unknown)	VER IN U.S. ARMED FORCES (If yes, give war or dates service)	1 フィブーフリーフエエル	Mr. Theodore	Broderick,		
9			RTIFICATION 12,3	04 Dewey Rd	.,Silver	INTERVAL DELABER
I. DISEASES OR CO	ONDITIONS DIRECTLY		,			ONSET AND DEATH
Immediat	e cause (a)	Coronary or	eclusion	000801.002.0081.1.000.000.004.000 . 21	o, wa'ee a neer ne neer of white w	sudden
Diseases or giving rise t	nt cause(s) conditions, if any, (b) o the above ceuse underlying cause last	<u> </u>				drash
II OTHER SIGNIE	(c) ICANT CONDITIONS					
Conditions contrib	uting to the death but not use or condition causing dea	th.				
		FINDINGS OF OPERATION				Yes No R
21. EXTERNAL CA PRIMARY OR C CAUSE OF DEAT	ONTRIBUTING 🗌 OF	CE (Home, farm, factory, street, office bldg., etc.) URY	(CITY O	R TOWN)	(COUNTY)	(STATE)
	(Day) (Year) (Hour) m.	INJURY OCCURRED While at Not while work at work	HOW DID INJURY	OCCUR?		
obtained by sa	id Autopsy, Inspection of	nins described above, held an Ar Inquiry, find that said dece , suicide , homicide , (Degree or title)	eased died on the any st	K, Inquiry A tated above, and de	hereon and fath in my	from the evidence opinion resulted DATE SIGNED
23. BURIAL, CREM	TATION DATE THERE		RY OR CREMATORY	LOCATION (City,		
Trans. & Bi	irial (5/28/55	Washington (New Orle		
DATE REC'D BY	LOCAL REGISTRAR'S	SIGNATURE Soller	24. FUNERAL DIRECT	waheer	8434 Ga.	ADDRESS AVE

SECEINE

BUREAU V. S.

479 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

			st. No. 🗸 / /
1. PLACE OF DEATH:		L RESIDENCE (HOME.) OF DECEAS	
		Maryland COUNTY Mon	
OR and reve nearest town)	(in this place) OR	If outside corporate limits, write RURAL ROCKVILLE	and give nearest town)
HOSPITAL OR MONTGOMERY Count INSTITUTION OR General Hospital)
3. NAME OF (First) (Middle Luge (Type or Print)		4. DATE (Month) OF DEATH: May	(Day) (Year) 8 19 55
5. SEX: 6. COLOR OR 7. SINGLE. MARRIED WIDOWED DIVOR (Specify): SINGLE	5/8/55		Days Hours Min.
OA. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Newborn	USTRY:	PLACE (State or foreign country): 12	
13. FATHER'S NAME:		HER'S MAIDEN NAME:	V . D . 11 .
Sidney Eugene Butt	Ja	nice Lorraine Conne	11v
(Yes, no, or unk.) (If Yes, give war or dates of service)	. SECURITY No. 17. INFO	rmant a address: ther	
IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)	Sumaturity &	121/ monts - silb z vz.	Mars.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	ne ne		
19a. DATE OF OPERATION: 19B. MAJOR FINDINGS	OF OPERATION		20. AUTOPSY?
21A. ACCIDENT WAS UNDERLYING 21B. PLACE OR CONTRIBUTING CAUSE OF DEATH OF INJURY (IF EITHER, NOTIFY MEDICAL EXAMINER)	(Home, farm, factory, street, office bldg., etc. INJUR	WHERE DID (City or town) (Courty OCCUR?	nty) (State)
21D. TIME (Month) (Day) (Year) (Hour) 21E INJ OF INJURY M. 21E While at work	URY OCCURRED 21F. HO Not while at work	SANDO VANENI DID WO	
22. I hereby certify that I attended the decease alive on May 5, 19-5., and that dease SIGNATURE	/ 14 4	from the causes and on the date	
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (SPECIFY)	ME OF CEMETERY OR CRE	NATORY LOGATION (City, town,	ST 9/55

MARGIN RESERVED FOR BINDING

atelicani (Supline mention ?) 11 des Summited (2 66 2 63

BUREAU V. S.

VS.

MARYLAND	STATE	DEPARTMENT	OF	HEALTH-BALTIMORE,	18
1400					

CERTIFICATE OF DEATH

RE, 18 ()4772 Reg. Dist. No. 2/6

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED	D:
COUNTY Mont comert MARYLAND	stateMaryland county Mon	tgomery
CITY (If outside corporate limits, write RURAL) LENGTH OF STAY	CITY(If outside corporate limits, write RURAL a	
OR and give nearest town) (in this place)	or Town Bethesda	×
HOSPITAL OR	STREET (If rural give location)	/
INSTITUTION OR STREET ADDRESS 4530 Avondale St., Apt.#	ADDRESS 4530 Avondale St., Rpt.	# 2
		# 2
3. NAME OF (First) (Middle) DECEASED:	(Last) 4. DATE (Month) (I	Day) (Year)
(Type or Print) MARY ANN FRANCES CARLTN 5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE	OF BIRTH: 9. AGE last birthday IF UNDER 1	19 55
RACE: WIDOWED, DIVORCED.	Months D	ays Hours Min.
Female White (Specify) Widowed Feb. 2	20.1870 85 yrs. 2 2	1
10A. USUAL OCCUPATION (Give kind of or NOT	(1. BIRTHPLACE (State or foreign country): 12.	CITIZEN OF WHAT
even if retired): Housewife Own Home	New Jersey	US
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	
James Cordock	Elizabeth Denin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES! 16. BOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:	
(Yes, no, or unk.) (If Yes, give war or dates of service)	Mr Jos. M. Cohan- Item # 2	
No lof service) None		INTERVAL BETWEEN
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		ONSET AND DEATH
1120.1 MYMART	DIA INFORMATION	DA HIND !
IMMEDIATE CAUSE (A)	MALIMANUM	上つかり
ANTECEDENT CAUSE (S)	RUTIDAMBADO	1
DISEASES OR CONDITIONS, IF ANY. (B)	NY INKIUSUOIO	, i
STATING UNDERLYING CAUSE LAST.	n c n cont c > c	-7
(c) AKIDKI	03/15/15/15	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE	♠ n.	
DISEASE OR CONDITION CAUSING DEATH.		
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATIO	N	20. AUTOPSY?
		YES NO
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fac	etory, 21c. WHERE DID (City or town) (Count	(State)
OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg.,	, etc. INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED	D 21F. HOW DID INJURY OCCUR?	
OF INJURY While at work at work		
22. I hereby certify that I attended the eccased from	, 1942, to MAY 1, 1953, that I last	saw the deseased
alive on MA, 1955, and that death occurred at	M, from the causes and on the date	stated above. re signed
SIGNATURE S WYNGOCIA WING	INTEGRALA WIN WACHE	00 51955
	ERY OR CREMATORY LOCATION (City, town, or	county) (State)
REMOVAL (SPECIFY)		
	nds-New York New York, Bro	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS

BECEINED

2361 91 YAM

BUREAU V. L.

rrect	4799	CERTIFICATE	OF DEATH	Reg. Dist.	No. 214
13	1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOM	E) OF DECEASED:	
A P	COUNTY Montannery	MARYLAND	STATE Maryland	COUNT	ry Montgome
S. die	CITY (If outside corporate limits, wr	ite RURAL LENGTH OF STAY	CITY (If outside corporate OR		
full le	56 TOWN Welver Ohn	na (in this place)	TOWN Silver Sp	ring	56
rarefully. The	HOSPITAL OR INSTITUTION OR STREET ADDRESS	West Holinia	STREET ADDRESS 1507 East	(If rural give location) West Highway	1
information	3. NAME OF DECEASED: (Type or Print)	(Middle)	(Last) A. DATE OF DEATH	(Month) (Day)	(Year)
inforn	5. SEX: 6. COLOR OR 7. SIN RACE: WILL	GLE, MARRIED, DOWED, DIVORCED, ecify):		birthday: IF ONOER 1 YEAR	AR IF UNOER 24 HR
G n of	IOa. USUAL OCCUPATION Give kind of work done during most of working life even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	II. BIRTHPLACE (State of f	oreign country): 12. Cl	OUNTRY OF WHA
FINI	13. FATHER'S NAME:	Danishan	14. MOTHER'S MATDEN NAME	Whin	40.
JR y e		of No.: 16. Social Security No.: 17.	INFORMANT & ADDRESS:	samehan 1.	wile I
		18. MEDICAL CERTIFICATION	ON		Interval Between
RESERVED NG INK. Su	1. DISEASES OR CONDITIONS DIRECT	able	Win		Onset And De
ESI G I		JE TO	0		101
	Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause	(b) scule Consu.	ac dilalim		House
ARGIN INFAD	stating the underlying cause last. DU	Amedia mancular ne	nel disease with his	Terlensin,	me year
100	Conditions contributing to the death by		m, angeria /1		0
WITH	19a. DATE OF OPERATION: 19b. MAJ				20. AUTOPSY
1 8	21. ACCIDENT (Specify) PI OF	ACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (ST	Yes No
PLAINLY pecially im		While at Not While	HOW DID INJURY OCCUR?		
	22. I hereby certify that I attended	the deceased from	,192,6, to 1 may	1955, that I last s	aw the decease
WRITE	alte on May, 1955, ar		, from the cause	es and on the date st	
WI	Muss Emallingly,	M.D. 2200 K	· Save 16. Wash	1.18,26 1	may 55
SE	BURIAL, CREMATION DATE THE			ION (City, town, or cour	//
5 EAS	DATE REC'D BY LOCAL REGISTRA	55 Ft. Lincoln (Grematory Prin	nce George Cou	ADDRESS
A11	REGISTRAR 5-5-5 Jean	see toller Y	Drugged Promphy	8434 Georg	ia Ave.

MAY 6 1955

BUREAU V. S.

STATE OF THE PARTY OF THE PARTY

m/	ne i	4800 MARYLAND STATE DEPARTMEN	T OF HEALTH—BALTIMORE, 18	04774
X	F	Item 11: film G182 6-2-55 CERTIFICATE	E OF DEATH Reg. Dist.	No. 216
1	ully.	1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED):
6	m of information carefully death clearly and legibly.	county Montgomery CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN rural - Kensington 4 months HOSPITAL OR INSTITUTION OR 3000 McComus Ave.,	STATE Maryland COUNTY Montg CITY(If outside corporate limits, write RURAL a OR TOWN rural - 4317 Saul R STREET (If rural give location) ADDRESS Kensington	nd give nearest town)
M)	m of inf	DECEASED: (Type or Print) Frederic Webster Ca	(Last) 4. DATE (Month) (I OF DEATH: May 2] OF BIRTH: 9. AGE last birthday I PUNDER I Y	
9	every item causes of de	RACE: WIDOWED, DIVORCED.	ber 11,1904 50 yrs. Months 11.	Bys Hours Min.
NIC	pply the ca	13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	0.0.
BINDING		Lewis Frederic Case	Lena Winkler	
FOR B	INK. se wri	(Yes, no, or unk.) (If Yes, give war or dates of service)	Mrs. Frederic Case, 4317	Saul Road
)ING plea	18. MEDICAL CERTIFICAT I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	ION	INTERVAL BETWEEN ONSET AND DEATH
SER	FAI	IMMEDIATE CAUSE (A) Probabl	e Pulmonary embolus	immediat
	TH UNFAI	ANTECEDENT CAUSE (5)	sclerosis; hypertension	18 yrs
(GI)	-	STATING UNDERLYING CAUSE LAST.	lonephritis	18 yrs
MARGIN	Jimes .	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
	4	194 DATE OF OPERATION: 198. MAJOR FINDINGS OF OPERATION	1	20. AUTOPSYT
1	WRITE PL especially	21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fact OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bidg., (IF EITHER, NOTIFY MEDICAL EXAMINER)	etc. INJURY OCCUR?	y) (State)
6	-	OF INJURY OF INJURY	21F. HOW DID INJURY OCCUR?	
	E OR	22. I hereby certify that I attended the deceased from Jan.	The state of the s	
10 - 53	TYP	alive on May 19, 1955, and that death occurred at SIGNATURE	Kensington, Md.	E SIGNED
15 —	PLEASE	23. BURIAL, CREMATION, DATE THEREO NAME OF CEMETE	ERY OR CREMATORY LOCATION (City, town, or	
V.S. A	PL1	DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR 5/23/55 Please M. Thompson	34. FUNTRAL PRECTOR	ADDRESS The sda . Md .

BUREAU V. S.

SECELVED MAY 26 1955

*

4754

CERTIFICATE OF DEATH

eg. Dist. No. 223 -

1. PLACE OF DEATH COUNTY NONTGOMERY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED. COUNTY MONTCO MEN
CITY (If outside corporate limits, write RURAL and OR give nearest town) AKOMA PARK (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN AKOMA ARK
HOSPITAL OR INSTITUTION OR STREET ADDRESS 251 MANOR CIRCLE	STREET (If rural, give location) ADDRESS 25/ MANOR CIRCLE
3. NAME OF (First) (Middle) DECEASED (Type or Print) BERTHA SHANKS	(Last) 4. DATE (Month) (Day) (Year) OF DEATH MAY 21, 19
5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVOROED, (Specify) / ARRIED	8. DATE OF BIRTH 9. AGE last birthday of under. 1 year Munder 24 hrs. Aug. 15, 1874 Soyrs. Months. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) CHATFIELD 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME	14. MOTHER'S, MAIDEN NAME JENNIE JOHNSON
15. Was DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY No. (Yes, no, or unknown) (If year, give war or dates of service)	17. INFORMANT AND ADDRESS 25/ MANUR CIRCLE, MRS JEANETTE WERMICH, TAKOMA PARK, Md.
18. MEDICAL CEI	RTIFICATION INTERVAL BETWEEN ONSET AND DEATE
420 / Immediate cause (a) Myocardia	a Infarction 4 weeks
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	is, Coronary & Generalized 10 yes.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Yes No 🗹
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bidg., etc.) HOMICIDE INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED While at Not While INJURY m. Work At work	HOW DID INJURY OCCUR?
alive on	19.55, to 2/ may, 19.55, that I last saw the deceased
23. BURIAL, CREMATION DATE , NAME OF CEMETER	RYOR CREMETORY (LOCATION (City, town, or county) (State)
ADATE REC'D BY LOCAL REGISTRATA SCINATURE	24. FUNERAL DIRECTOR ADDRESS.
May 21-1955 J-1000m DOOL	V. arthur Walters, 254 Carrall SL Ned Tok Pa
	1) Ac.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The

VS. A15-10-53

MARYLAND STATE DEPARTMEN	T OF HEALTH—BALTIMORE, 18	04776
4891 CERTIFICATI	E OF DEATH Reg. Dist.	No. 5/6
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASE	D:
COUNTY Montgomery MARYLANO	STATE Pa. COUNTY	
CITY (If outside corporate limits, write RURAL LENGTH OF STAY	CITY(If outside corporate limits, write RURAL a	nd give nearest town
X TOWN Bethesda (in this place)	TOWN Pittston	75 X -3
HOSPITAL OR The Clinical Center	STREET (If rural give location)	V
50 STREET ADDRESS Natl. Institutes of Health	132 Elizabeth St.	
3. NAME OF (First) (Middle)	(Last) 4. DATE (Month) (I	Day) (Year)
DECEASED: (Type or Print) Edward J. Co.	nnors OF DEATH: May	27 1955
5. SEX: 6. COLOR OR 7. SINGLE, MARRIED. 8. DATE RACE: WIDOWED, DIVORCEO,	of BIRTH: 9. AGE last birthday Months D	EAR IF UNDER 24 HRS.
NOA. USUAL OCCUPATION (Give kind of work done during most of working life. OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): 12.	CITIZEN OF WHAT
Nanager (Retired) Bowling Alley 13. FATHER'S NAME:	Pennsylvania	U.S.A.
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	
Luke Connors	Margaret Curley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES! 16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:	
(Yes, no, or unk.) (If Yes, give war or dates Not available	The medical record. The Clinic	al Center
18. MEDICAL CERTIFICAT		INTERVAL BETWEEN
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		ONSET AND DEATH
IMMEDIATE CAUSE (A) Carcinoma	of maxillary antrum with	
	to lung, liver, abdominal and	
DISEASES OR CONDITIONS, IF ANY. (B) thoracic 1	ymph nodes	
GIVING RISE TO THE ABOVE CAUSE OUE TO STATING UNDERLYING CAUSE LAST.		HE PERSON
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE		
DISEASE OR CONDITION CAUSING OBATH. Bronchopne		
194. DATE OF OPERATION: 198. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
7-0		
21A. ACCIDENT WAS UNDERLYING \(\) 21B. PLACE (Home, farm, factor of the contribution \(\) CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	etc. INJURY OCCUR?	y) (State)
OF INJURY OF INJURY M. 21E INJURY OCCURRED While Not while at work at work 21E INJURY OCCURRED While 21E I	21F. HOW OIO INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Apr.	15 , 19.55 to May 27 , 19.55 that I last	saw the deceased
alive on May 27 , 1955, and that death occurred at	12:55 M, from the causes and on the date	
Harold Ulman, M.D. M	O. Natl Institutes of Health ERY OF CREMATORY LOCATION (City, town, or	5/27/55
REMOVAL (SPECIFY)		county) (State
Burial-Transit 5-30-55 St. Johns		THE RESERVE OF
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	FUNDRAS DIBECTOR	ADORESS

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PLEASE TYPE OR WRITE PLAJKLY, WITH UNFADING INK.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04777

Bethesda, Md.

CERTIFICATE	Reg. Dist. No. 22/20
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:
county Montgomery Maryland	STATE W. Virginiacounty Wyoming
CITY (If outside corporate limits, write RURAL or and give nearest town) X TOWN Bethesda LENGTH OF STAY (in this place) 115 days	CITY(If outside corporate limits, write RURAL and give nearest town OR TOWN Pineville 85X-3
	STREET (If rural give location)
HOSPITAL OR THE Clinical Center Sostreet Address National Institutes of Health	ADDRESS
3. NAME OF (First) (Middle) (DECEASED: (Type or Print) Booster Charles	(Last) 4. DATE (Month) (Day) (Year) OF DEATH: May 28 1955
5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE WIDOWED, DIVORCED,	OF BIRTH: 9. AGE last birthday F UNDER ! YEAR IF UNDER 24 HRS. Months Days Hours Min.
Male White (Specify): Married July 2 10A. USUAL OCCUPATION (Give kInd of work done during most of working life, even if retired): Miner USUAL OCCUPATION (Give kInd of OR INDUSTRY: OR INDUSTRY: United Mine Worker	11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHA COUNTRY?
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
William Cook	Joclie Workman
15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates	The medical record. The Clinical Center
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE ANTECEDENT CAUSE (8) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)	elitis with Suppurative hepatit de l'acces
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION My 16 185 Subolicy by Major Sie 21a. ACCIDENT WAS UNDERLYING 21b. PLACE (Home, farm, fact OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg.,	alscess intestinal obstantion (State)
(IF EINTHER, NOTIFY MEDICAL EXAMINER) 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. 21E INJURY OCCURRED While Not while at work at work	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Feb.	2 . 1955, to May 28 . 1955, that I last saw the decease
alive on May 28 1975, and that death occurred at SIGNATURE	
Burial-transit /5/28/55 Mullens	Mullens W. Virginia
DATE REC'D BY LOCAL BEGISTRAR'S SIGNATURE	1, 24, AUNERAL DIRECTOR ADDRESS

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4803 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

()4778 L Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.	MEDICAL	EXAMINER'S	CERTIFICATE	OF	DEATH	No.21
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I. PLACE OF DEATH:		
	2. USUAL RESIDENCE (HOME) OF DECEASED:	
county Montgomery maryland	state Maryland county Montgo	omery
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Kensington LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL an OR TOWN Kensington	d give nearest town)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4407 Clearbrook Lane	STREET (If rural, give location) ADDRESS 4407 Clearbrook Lai	
3. NAME OF (First) (Middle) DECEASED: (Type or Print) Harry Armand	COX Sr. 4. DATE (Month) (Da OF DEATH 5	y) (Year) 9 19 55
PACE: WIDOWED DIVORCED		YEAR IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Naval Architect Architect	· I and an I'm aloud	COUNTRY? United Stat
I3. FATHER'S NAME: Harry A. Cox	14. MOTHER'S MAIDEN NAME: Emma Col.	lins
15. Was Deceased Ever In U.S. Armed Forces? (Yes, no, or unk.) (If Yes, give war or dates of Yes Sprice) ish Amer. 577-38-5440-A	17. INFORMANT & ADDRESS: Harry A. C 4906-Blackfoot Rd. Colleg	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: HOO, I Immediate cause (a) DUE TO Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last	cclusion	INTERVAL BETWEEN ONSET AND DEATH Sudden
stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes \(\text{No} \(\text{No} \)
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION: 21a. EXTERNAL CAUSE WAS 12b. PLACE (Home, farm, factory)		Yes 🗆 No 🖪
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION: 21a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING OF Street, office bldg., etc. INJURY 21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED OF While at Not while	bed above, held an Autopsy , Inspection dent , Suicide , Homicide , Undete CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM.	Yes No A. (State) , Inquiry A, and ermined cause DATE SIGNED S-9-1-1 (Ounty) (State)

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CERTIFICATE OF DEATH

	8	
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED):
county Montgomery Maryland	STATE Ohio COUNTY	
CITY (If outside corporate limits, write RURAL LENGTH OF STAY	CITY(If outside corporate limits, write RURAL at	nd give nearest town
OR and give nearest town) (in this place)	OR TOWN Tolerand	771 2
bethesda 1 35 days	STREET (If rural give location)	1001-0
NINSTITUTION OR THE CLIMICAL CENTER	ADDRESS (If Fural give location)	1
OSTREET ADDRESS Natl. Institutes of Health	1673 Bunts Road	V
3. NAME OF (First) (Middle) ((Last) 4. DATE (Month) (E	Day) (Year)
DECEASED: (Type or Print) Samuel Edward Cr	rozier OF DEATH: May	16 1955
5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE	OF BIRTH: 9. AGE last birthday IF UNDER 1 Y	
RACE: WIDOWED, DIVORCED,	Months D	ays Hours Min.
M W (Specify): Married July 16		-
work done during most of working life OP INDUCTOV.	11. BIRTHPLACE (State or foreign country): 12,	COUNTRY?
even if retired): Stockman Private industry	New York	U.S.A.
3. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	
Wm. Crozier	Martha Phillips	
S. WAS DECEASED EVER IN U.S. ARMED FORCES! 16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:	
(Yes, no, or unk.) (If Yes, give war or dates		
Yes of service) WW I & II 297-30-7590	The medical record, The Clinica	1 Center
18. MEDICAL CERTIFICATI	ION . O .	INTERVAL BETWEEN
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	in partie	ONSET AND DEATH
Cellulitis,	, right leg with overwhelming,	2-3 1-4-
IMMEDIATE CAUSE (A) COLLUITORS	On and and and and and and and and and an	a says
ANTECEDENT CAUSE (S)	and the	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO	inemia .	
STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE		
DISEASE OR CONDITION CAUSING DEATH.		
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
None 2		YES NO
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, factor of CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg.,	ory, 21c. WHERE DID (City or town) (County etc. INJURY OCCUR?	y) (State)
IF EITHER, NOTIFY MEDICAL EXAMINER) NONE		
TID. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while	21F. HOW DID INJURY OCCUR?	
M. at work at work		
22. I hereby certify that I attended the deceased from Apr.	11 1955 to May 16 1955 that I leat	saw the decease
	3:504 M, from the causes and on the date s	
SIGNATURE 10. M SI MANN!	The Clinical Center	E SIGNED
	D. Natl. Institutes of Health	
23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETE	ERY OR CREMATORY LOCATION (City, town, or	county) (State)
unal-Transit 5-17-55 June Hil	1 Duffalo, N.	y
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS/
REGISTRAR -/ 10	1111. 1111.	6 - 1/

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The MARGIN RESERVED FOR BINDING

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-	CERTIFICATE			st. No.		
ı	1. PLACE OF DEATH:	2. USUAL RESIDE	NCE (HOME) OF DECEAS	ED:		
	county Montgomery Maryland	state Marv]	land county Mo	ntgon	nerv	
	CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) (in this place)	() IS	corporate limits, write RURAI	and gi	ve neare	st town
7	Town Bethesda 35 days	TOWN Betthe	esda			×
	HOSPITAL OR The Clinical Center	STREET	(If rural give location	n)		1
	STREET ADDRESS Natl. Institutes of Health	Pooks	Hill Apt. #303			
	3. NAME OF (First) (Middle) DECEASED: Transaction	(Last)	4. DATE (Month)	(Day)	(Ye	ear)
-	(Type or Print) William Franklin Cu	ummins ·	OF DEATH: May	3	19	55
5	M 6. COLOR OR 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married December December		AGE last birthday IF UNDER Months Months	Days Days	Hours	Min.
o	A. USUAL OCCUPATION (Give kind of work done during most of working life. OR INDUSTRY:	11. BIRTHPLACE (S	State or foreign country): [12	CITIZ	EN OF	WHAT
	even if retired): Engineer Private industry	Mississin	ppi	UOU!	S.A.	
1:	3. FATHER'S NAME:	14. MOTHER'S MA				
	William Cummins	Janie Pic	ckett			
	WAS DECEASED EVER IN U.S. ARMED FORCES? 18. SOCIAL SECURITY NO.	17. INFORMANT &	ADDRESS:			
	Yes, no, or unlaw (If Yes, give war or dates of service) W.W. #2 Not available	The medical r	record, The Clini	cal C	ente	r
	18. MEDICAL CERTIFICAT I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	ION			RVAL E	DEATH
	151X IMMEDIATE CAUSE (A) Careinone	1 Stoma	el		44.	
	ANTECEDENT CAUSE (S)	0				
	DISEASES OR CONDITIONS, IF ANY, (B)	117/1				
	GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST.					
	(C)					
1	TO THE SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE					
	DISEASE OR CONDITION CAUSING DEATH			_		
1	Mark install				AUTO	
	- Ca Joman		- 104			№ □
	11A. ACCIDENT WAS UNDERLYING 21 PLACE (Home, farm, fact R CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., if either, notify medical examiner)		17	inty)	(St	ate)
	1D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while at work at work	21F. HOW DID IN	NJURY OCCUR?			
5	22. I hereby certify that I attended the deceased from Mar.	29, 19 55, to Ma	av 3 . 1955, that I la	at saw	the de	200000
1	alive on May 3 , 19.55, and that death occurred at					
	SIGNATURE	ADDRESS	n	ATE SI		e.
	Joseph & Cholder M.	D. Natl. Inst	al Center itutes of Health	5-	3-5	5
2	BURIAL, CREMATION. DATE THEREOF NAME OF CEMETE	RY OR CREMATORY	LOCATION (City, town,	or count		(State
	May 6, 1955 MG		Martinis Jer	ry,	7 to	10
1	DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	24. FUNERAL DI	PECTOR A	AD	DRESS	
	REGISTRAR 5 14 155 18 CALL M LL TOR BATTE		wlers Down 12	1		

DECEIVED AMY 6 1955

BUREAU V. S.

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1. PLACE OF POATH:	2. USUAL RESIDENCE (HOME) OF DECEASED	D:
COUNTY // (MY 4 or end) MARYLAND	STATE Many welcounty Mor	My oney
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN LENGTH OF STAY (in this place)	CITY(If outside comborate limits, write RURAL a	nd live nearest town
HOSPITAL OR INSTITUTION OR	STREET (If rural rive location)	2 7191
of STREET ADDRESS 109 Linestry We	109 fracet	m are
3. NAME OF (First) (Middle) DECEASED: (Type or Print) Walter	(Last) 4. DATE (Month) (I	Day) (Year)
5. SEX: 6. COLOR OR 7. SINGLE. MARRIED. 8. DATE MIDOWED, DIVORCED, (Specify): WIDOWED A Private A priv	OF BIRTH: 9. AGE last birthday IF ONDER 1 Y	ays Hours Min
OA. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	11. BIRTHPLACE (State or foreign country): 12.	COUNTRY?
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	
Henry Delane:	Lucinoa Kina	
(Yes, no, or unk.) (If Yes, give war or dates of service)	Louise Delaney, 109 Lin	cci. Al
18. MEDICAL CERTIFICAT	TION	INTERVAL BETWEE
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	2 11	ONSET AND DEAT
IMMEDIATE CAUSE (A) Cerebral	Here orthage	36 less
ANTECEDENT CAUSE (8) DISEASES OR CONDITIONS, 1F ANY. (B)	News classis Generaling	1041
STATING UNDERLYING CAUSE LAST. DUE TO		
(C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING		
TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH,		
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION	N	20. AUTOPSY?
0		YES NO
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, factor CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., (IF EITHER, NOTIFY MEDICAL EXAMINER)	tory. 21c. WHERE DID (City or town) (Count injury occur?	y) (State)
21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while at work at work	2 21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 25-	M., 1953, to 1.2 May, 1953, that I last	saw the decease
alive on /2 May , 1953, and that death occurred at	7 M, from the causes and on the date s	stated above.
1713 dulla	1. D. 7/12 Wellow Ave a l'orle 1	2May 1955
REMOVAL (SPECIFY)	ERY OR CREMATORY LOCATION (City, town, or	county) (State
DATE REC'D BY LOCAL REGISTEAR'S SIGNATURE //	24. FUNERAL DIRECTOR	ADDRESS
REPUSTBARIA - 1051 ATTENDED DETAIL	1115 7 1129	11 (+ 1/1

BUREAU V. S.

2361 **31 YAM**

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	CERTIFICATI	Z OF DEATH Reg. DIS	t. No. 2 2
Ag &	1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASE	:D:
carefully legibly.	COUNTY Wouldowley MARYLAND	STATE Marifaeld COUNTY Mos	clasunau
/ .	CITY (If outside converate limits, write BURAL LENGTH OF STAY OR and give negret town) TOWN Jalanua Jaken	CITY(If outside corporate limits, write RURAL OR TOWN Jakousa Cark	and give nearest tow
m of information death clearly and	HOSPITAL OR INSTITUTION OR THE STREET ADDRESS 7600 Hammand ave	STREET ADDRESS DE DE L'ACTION	ase.
of ath	3. NAME OF (First) DECEASED: (Type or Print) GETTVAE (Middle) Den	Mibera OF DEATH: Way	(Day) (Year) 24 1955
ite	5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE WIDOWED, DIVORCED, Oprif	//880 / 3 yrs.	Days Hours Min
ever ever	10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS work done during most of working life or INDUSTRY:	F1. BIRTHPLACE (State or foreign country): 12.	COUNTRY?
Supply te the	13. FATHER'S NAME: Cohou	14. MOTHER'S MAIDEN NAME:	
NK.	15. WAS DECEASED EVER IN U.S. ARMED FORCEST 18. SOCIAL SECURITY NO. (Yes, no, or unk.) (If Yes, give war or dates of service)	241s. aux Louday = 7600 ft	annough
RESERVED F UNFADING I sicians: pleas	I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	TION Samo	INTERVAL SETWE
FA	IMMEDIATE CAUSE (A)	Occlusion, aux	(made)
RE UN Sicia	ANTECEDENT CAUSE (S)	00 - 4 - 96 - 4 Day on	Transaction -
MARGIN Y, WITH tant. Phys	GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	contra promy 195 mile	- dr
AR W	(C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING		
M. Y,	TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
up odu	19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION	N	20. AUTOPSY
I PA			YES NO
TTE PL	21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fac OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., (IF EITHER, NOTIFY MEDICAL EXAMINER)		nty) (State)
R WRITE	OF INJURY (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while at work at work	21F. HOW DID INJURY OCCUR?	
TYPE OF	22. I hereby certify that I attended the deceased from alive on 5 2 3 , 19 5, and that death occurred at SIGNATURE	530 / M, from the causes and on the date	
EASE	23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMET BEMOVAL (SPECIFY) May 24/1955 Clesavely	ery or crematory Location (City) town of	or county) (Sta

SECENTED NAV. 26 1955

BUREAU V. S.

24 FUNERAL DIRECTOR 2901 Lith Street, N.W., Washington, D.C.

DATE REC'D BY LOCAL

REGISTRAR

REGISTRAR'S SIGNATURE

CERTIFICATE OF DEATH Reg. Dist. No. 215 carefull 1. PLACE OF DEATH: 2. USUAL RESIDENCE (HOME) OF DECEASED: legibly. COUNTY Montgomery COUNTY Montgomery STATE Maryland MARYLAND CITY(If outside corporate limits, write RURAL and give nearest town) CITY (If outside corporate limits, write RURAL) LENGTH OF STAY and give nearest town) (in this place) and information X TOWNBethesda, Rural TOWN 27 days Takoma Park HOSPITAL OR STREET (If rural give location) clearly INSTITUTION OR ADDRESS 1100 Linden Ave., Apt 201 street address U. S. Naval Hospital (First) (Middle) (Last) 3. NAME OF 4. DATE (Month) (Year) death of DECEASED: Ellsworth Calvin DE VAUGHN DEATH: May (Type or Print) item 6. COLOR OR 17. SINGLE, MARRIED. B. DATE OF BIRTH: 9. AGE last birthday IF UNDER I YEAR 5. SEX: IF UNDER 24 HRS WIDOWED, DIVORCED, RACE: Months White (Specify): Widowed 27 October 1893 Male every IOA. USUAL OCCUPATION (Give kind of) 10B. KIND OF BUSINESS 11. BIRTHPLACE (State or foreign country): |12. CITIZEN OF WHAT work done during most of working life, OR INDUSTRY: U.S. BINDING even if retired): Govt Employee Washington, D.C. U. S. Govt Supply 14. MOTHER'S MAIDEN NAME: 13. FATHER'S NAME: Walter C. DE VAUGHN Jane F. BERNISTON 17. INFORMANT & ADDRESS: 10608 Edgewood Ave. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. FOR INK. (Yes, no, or unk.) (If Yes, give war or dates of service) WI WWII Walter C. DE VAUGHN Silver Spring. Md. Unknown 18. MEDICAL CERTIFICATION INTERVAL BETWEEN ADING MARGIN RESERVED I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH ONSET AND DEATH Physicians IMMEDIATE CAUSE DUE TO ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY. (B) WITH GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. important. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING PLAINLY, TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH 19A. DATE OF OPERATION: 198. MAJOR FINDINGS OF OPERATION **AUTOPSY?** 21A. ACCIDENT WAS UNDERLYING [] 21B. PLACE (Home, farm, factory, 21c. WHERE DID (City or town) (County) (State) 田 OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., etc. INJURY OCCUR? (IF EITHER, NOTIFY MEDICAL EXAMINER) 21E INJURY OCCURRED 21F. HOW DID INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) Not while While at work at work OR 22. I hereby certify that I attended the deceased from 2 May, 1955, to 29 May, 1955, that I last saw the deceased 田 TYPI DATE SIGNED USN U. S. Naval Hospital M. D.NNMC. Bethesda. Marvland SE NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) 23. BURIAL, CREMATION. DATE THEREOF REMOVAL (SPECIFY) Arlington National Cemetery Arlington, Virg June 1955

BUREAU V. S.

SS6T 9 NNr

BECEINED

VS. A15

48 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04785

1. PLACE OF DEATH	II. STEOMERY	MARYLAND	2. USUAL RESIDENCE (H		COUNTY
CITY (If outside c	orporate limits, write RUR.		CITY (II outside corpora	to limits write DIIDAI	and give respect topic
OR give nearest	town) SILVER SPRI	' (in this place)	TOWN WASH	4INGTON	and give nearest town)
HOSPITAL OR INSTITUTION OF STREET ADDRE	IL TO THE PARTY OF	IRSING HOME SUILLE RD.	STREET ADDRESS 3319F	ESENDEN	ST. N.W.
3. NAME OF DECEASED (Type or Print)	(First) NELLIE	VINCENT I	DISHMAN	4. DATE (Mon OF DEATH MAY	th) (Day) (Year) 1955
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specily)	S. DATE OF BIRTH 29FEB. 1871	01/	f under I year If under 24 hrs. Months Days Hours Min.
done during most of	ATION (Give kind of work working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	ALEXANDRIA	VA.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAM	IE ,	NCENT	14. MOTHER'S MAIDEN SINA SIM		
	VER IN U.S. ARMED FORCES (If yes, give war or dates of service)		17. INFORMANT AND EUSTACE M. PE		19 FESENDENSTN ASHINGTON D.C.
		18. MEDICAL CE	RTIFICATION		1
I. DISEASES OR CO	ONDITIONS DIRECTLY	LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATE
Immediat	e cause (a)	BRONCHOPI	NEUMONIA	*** ***********************************	2/2 Mas.
Diseases or	nt cause(s) conditions, if any, (b) the above cause	SENILITY.			-0.00 00 00 00 00 00 00 00 00 00 00 00 00
stating the u	inderlying cause last (c)	ARTIOSCLEROSIS PARKINSONISM	S		
Conditions contribu	CANT CONDITIONS uting to the death but not se or condition causing deat	h.			
19a. DATE OF OPE	RATION 19b. MAJOR I	FINDINGS OF OPERATION			20. AUTOPSY?
0					Yes No ox
21. ACCIDENT SUICIDE HOMICIDE	(Specify) PLA	CE (Home, farm, factory, street, office hidg., etc.)	(CITY OR T	OWN) (CO	UNTY) (STATE)
	(Day) (Year) (Hour)	INJURY OCCURRED While at Not While Work At work	HOW DID INJURY OCC	CUR?	
22. I hereby cert	/ /	e deceased from OCT.	/ ^		
alive on MA	y 39 , 1955, an	d that death occurred at (Degree or title)	ADDRESS from the	causes and on the	late stated above. DATE SIGNED
/ / /	wed C. Whe	te maj. mc		CermyHow	7
23. BURIAL, CREM REMOVAL (Spec	val 5/291	55	6		opeounty) (State)
DATE REC'D BY	LOCAL REGISTRARS	SIGNATURE)	24. FUNERAL DIRECTO	S 5	ADDRESS VA
				- 0000	Jan. oa
				mel. no.	827

2361 8 NUL

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UNFADING INK.

PLEASE TYPE OR WRITE PLAINLY, WITH

Supply every item of information carefully.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 4879

,		0/1786
		A THE OFF
Reg.	Dist.	04786 No. 2/7

CERTIFICATI	E OF DEAT	H Reg. D	Dist. No. 2 / 7
1. PLACE OF DEATH:	2. USUAL RESIDEN	CE (HOME) OF DECEA	SED:
COUNTY MONTGOMERY MARYLAND CITY (If outside corporate limits, write RURAL or and give nearest town) X TOWN Olney MARYLAND LENGTH OF STAY (in this place) Z days	OR CITY(If outside cor	land county Morporate limits, write RURA	ontsomery Landgive nearest town
HOSPITAL OR Montgomery County Mostitution or General Hospital, Inc	STREET ADDRESS	(If rural give location	ion)
DECEASED: William Henry Do	(Last) Wling	4. DATE (Month) OF DEATH: May	(Day) (Year) 25 19 55
Male 6. COLOR OR 7. SINGLE, MARRIED, WIDOWED, DIVORCED, 3/1	6/1892	AGE last birthday IF UNDE Months yrs.	Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Harmer OR INDUSTRY:	Maryland	ate or foreign country):	COUNTRY?
13. FATHER'S NAME:	14. MOTHER'S MAIL	DEN NAME:	
George E. Dowling	Elizabet	n Efford	
(Yes, no, or unk.) (If Yes, give war or dates of service)	Hospital 1		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH HAT A CALLE (A) IMMEDIATE CAUSE ANTECEDENT CAUSE (S)	rassive Pulmon	any Edema	onset and death
DISEASES OR CONDITIONS. IF ANY. GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Hyperfe	five Heart usine Heart	Disease	5-6 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
194. DATE OF OPERATION: 198. MAJOR FINDINGS OF OPERATIO	N		20. AUTOPSYT
21A. ACCIDENT WAS UNDERLYING OF PLACE (Home, farm, factor of CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg. (IF EITHER, NOTIFY MEDICAL EXAMINER)		(City or town) (C	ounty) (State)
OF INJURY OF INJURY	4		
22. I hereby certify that I attended the deceased from alive on May 24, 1955, and that death occurred at SIGNATURE Ruhan a. Cale	A.M. from the ADDRESS	1 5	DATE SIGNED
Burace May 28/953 Parkla	ERY OR CREMATORY	LOCATION (City, town	722
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	24. FUNERAL DIR	ECTOR	ADDRESS



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· 中国主义的特别的首先与国际政策的关系。 作品 "可以同种类别大规范数,因为"文学" 有形态 医多种疾病

APPROXIMATION OF THE PARTY OF T

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

2411 N. Charles Street, Baltimore

04787

	CERTIFICAT	TE OF DEAT	TH Reg. Dis	1. No. 223-
1. PLACE OF DEATH- COUNTY Montgomure	MARYLAND	STATE M.	(HOME) OF DECEASED.	UNTY To Seo.
CITY (If outside corporate limits write RUR OR give nearest town) TOWN	AL and LENGTH OF STAY (in this place)	OR TOWN Syate	prate limits, write RURAL a	. 161512
HOSPITAL OR ON INSTITUTION OR TOP STREET ADDRESS 708 Philade	exhia are.	STREET ADDRESS 6/0	3 Eastern W	s. of 102.V
3. NAME OF DECEASED (First) (Type or Print) (First) JESSIE	(Middle)	EARMAN .	4. DATE (Month OF DEATH MAY	(Day) (Year) /9 19 5 8
Semal 6. COLOR, OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH Aug. 25, 1872	82 yrs. Mo	onths. Days Hours Min.
10s USUAL OCCUPATION (Give kind of work gone during most of working life, even if retired)	10b KIND OF BUSINESS OR	PRINCE KOWAKD	SLAND, GANADA	12. CITIZEN OF WHAT COUNTRY? USA
JOHN MAC DONALD		MARGARET	PERCIVALE	
15. WAS DECRASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If year, give war or dates of service)	? 16. Social Security No.	Ms. Louise Coff	man, 6103 Eastern	av. Hyates. Ad
I. DISEASES OR CONDITIONS DIRECTLY	18. MEDICAL CH	ERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	i) Cerebral	Thrombo	5/5	6 mo.
202 Antecedent cause(s)	2) Generaliz	eccl Arter	-ios deros	IS te Comero L
Diseases or conditions, if any, (b) giving rise to the above cause stating the underlying cause last	3) Cerebro	-Sclerosi	S	neletemen
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing deat	h.	AND A RELIGIOUS AND		and the same of
	FINDINGS OF OPERATION			20. AUTOPSY?
21. ACCIDENT (Specify) PLA SUICIDE OF INJU	CE (Home, farm, factory, street, office bldg., etc.)	(CITY OR	TOWN) (COUR	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at Not While Work At work	HOW DID INJURY O	CCUR?	
22. I hereby certify that I attended the alive on 1955, an SIGNATURE	e deceased from	A 1 1 1 1	e causes and on the da	
Aurel Loal	PAID 3	135 Easte	is my	May 19, 1953

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V	OR
10 - 53	TYPE
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	A OT DIARIT Reg. Dist. No. Sc./
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:
COUNTY Montgomery MARYLAND	STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Chevy Chase CITY (If outside corporate limits, write RURAL (in this place) One year	CITY(If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4757 Chevy Chase Drive	STREET (If rural give location) 4757 Chevy Chase Drive
	(Last) 4. DATE (Month) (Day) (Year) OF DEATH: May 1 19 55
Female White Widowed, Divorced, (Specify): Married Oct.	9. AGE last birthday IF UNDER 1 YEAR HOURS Min. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife Own Home	11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Oscar King	Elizabeth Chandler
(Yes, no, or unk.) (If Yes, give war or dates of service) No. 15. Social Security No. No.	Karl V. Eiker-Same Item #2
18. MEDICAL CERTIFICAT	INTERVAL BETWEEN
467. IMMEDIATE CAUSE (A) Combre) voccular accident 10 who
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY. (B)	O telangertania Canality
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING	-0 0:
TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	in arlen disease 5 yrs.
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES NO
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fact OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., (IF EITHER, NOTIFY MEDICAL EXAMINER)	tory, etc. 21c. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while at work at work	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from	6 1955 to Way 1 1955 that I last saw the deceased
alive on	12:47 M, from the causes and on the date stated above. ADDRESS DATE SIGNED 10. 7852 16. 4 W Waltz 5 //55
Burial 5/3/1955 NAME OF CEMETE Burial Parklawn	ERY OR CREMATORY LOCATION (City, town, or county) (State) Montgomery Maryland
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR 5/455 Bessie M. Hombron	Paletha Fumbhrey Bethesda, Mo

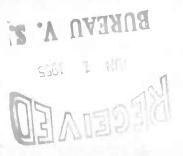
2381 3 YAM

BECEINED

Indicusing Vision Page 1

4810 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04788 CERTIFICATE OF DEATH Reg. Dist. No. 213

1. PLACE OF DEATH: In antigomery	2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY TO AND STATES MARYLAND	STATE Hayland COUNTY Moulowners	u
CITY (If outside corporate limits, write RURAL, LENGTH OF STAY	CITY(If outside corporate limits, write RURAL and give neares	
TOWN (in this place)	OR TOWN	V
HOSPITAL OR	STREET (If rural give location)	
PINSTITUTION OR STREET ADDRESS 7 Locks Road	ADDRESS	
	(Last) 4. DATE (Month) (Day) (Yes	ar)
DECEASED: (Type or Print) Omily Bloudlyd Col	OF DEATH: 5/30 19	
S. SEX: 16. COLOR OR 17. SINGLE. MARRIED. 1 8. DATE	OF BIRTH: 9. AGE last birthday IF UNDER 1 YEAR IF UNDER	
Female, Partil- (Specify): make & Steple	17/1911 7+3 yrs. Months Days Hours	Min.
DA. USUAL OCCUPATION (Give kind of 108. KIND OF BUSINESS	11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF	WHAT
work done during most of working life. even if retired):	Maryland mulgon	6
3. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	T
Dourlas M. Blandford	Emily yellott	1
WAS DECEASED EVER IN U.S. ARMED FORCEST 18. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:	2 1
(Yes, no, or unk.) (If Yes, give war or dates of service)	John C. Colgin - Box 483-1 for	brelle
18. MEDICAL CERTIFICAT	//	ETWEEN
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	ONSET AND	DEATH
IMMEDIATE CAUSE (A) Carcenor	in af right bright, 4%	uper.
ANTECEDENT CAUSE (S)	A	
DISEASES OR CONDITIONS, IF ANY, (B)	metrolicas le lungo.	
STATING UNDERLYING CAUSE LAST. DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE	7.	
DISEASE OR CONDITION CAUSING DEATH.	none	
198. MAJOR FINDINGS OF OPERATION	20. 4010	PSY?
Vetober 19 50 Curumoma of ugo	y sould	
21A. ACCIDENT WAS UNDERLYING \(\) PRECONTRIBUTING \(\) CAUSE OF DEATH OF INJURY street, office bldg., (IF EITHER, NOTIFY MEDICAL EXAMINER)		ite)
21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY CCURRED	21F. HOW DID INJURY OCCUR?	
OF INJURY While Work at work		
22. I hereby certify that I attended the deceased from	95,6 tolkay 30, 19.55 that I last saw the de	ceased
	M, from the causes and on the date stated above	
SIGNATURE DA LAGT	ADDRESS DATE SIGNED	1
	.D. Kocherly, My. May 30,	15
REMOVAL (SPECIFY)	ERY OR CREMATORY LOCATION (City, town, or couply)	(State)
Burial Amt 2/55 Monaca	acy Deallsville - Mai	ylan
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR ADDRESS	& mi
113/11 / 01111 / 12 / 14/1/1/1/1/	1 I I TO TOTAL TO A STANDARD TO THE FACILITY OF THE PARTY	Le, 11/10



SIGNATURE

24.

FUNERAL DIRECTOR

REGISTRAR'S

DATE REC'D BY LOCAL

REGISTRAR 6

(Day)

Days

(Year)

19 5

IF UNDER 24 HRS.

INTERVAL BETWEEN

AUTOPSY? NO

(State)

Hours

12. CITIZEN OF WHAT

COUNTRY;

20.

DATE SIGNED

(County)

RESERVED

AI



K		4813 CERTIFICAL	E OF DEATH Reg. Dist. No. 212
4	carefully legibly.	1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:
U	carefull legibly.	COUNTY Montgomery MARYLAND	STATE Virginia county Arlington
	ation ca	CITY (If outside corporate limits, write RURAL on and give nearest town) X TOWN CITY (If outside corporate limits, write RURAL (in this place) (in this place) 10hrs 25 min	CITY(If outside corporate limits, write RURAL and give nearest town OR
(1	item of informati	HOSPITAL OR SINSTITUTION OR STREET ADDRESS U. S. Naval Hospital	STREET (If rural give location) ADDRESS 2801 North Somerset Street
1	of ima	3. NAME OF (First) (Middle) DECEASED: (Type or Print) Clifton Joseph	(Last) 4. DATE (Month) (Day) (Year) OF DEATH: 4 May 19 55
		5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE WIDOWED, DIVORCED,	OF BIRTH: 9. AGE last birthday IF UNDER 1 YEAR HOURS Min
5NG	r every causes	OA. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner Mariner Retired	II. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT COUNTRY? Louisana US
Id	Supply te the	13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Z	Sup te t	Simon FALCON	DRALIN ALLMAN
FOR BINDING	NG INK. Suplease write	(Yes, no, or unk.) (If Yes, give war or dates 15. Social Security No. (Yes, no, or unk.) of service) WW II Korea 579 44 7039	Mrs. Mary E. FALCON (WIFE) Same asabove
MARGIN RESERVED	WITH UNFADING nt. Physicians: plea	ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING	ory artery years
M	Y,	TO THE DEATH BUT NOT RELATED TO THE	
	PLAINLY, W	DISEASE OR CONDITION CAUSING DEATH. 19a. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES XX NO
I	TE	21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg.	ctory, 21c. WHERE DID (City or town) (County) (State) ,, etc. INJURY OCCUR?
	-	OF INJURY (Day) (Year) (Hour) 21E INJURY OCCURRE While Not while at work at work	D 21F. HOW DID INJURY OCCUR?
5 - 10 - 53	PLEASE TYPE OR correct age is	M. E. FLIPSE ICDR. MG. USN 23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMET	5:25M, from the causes and on the date stated above. ADDRESS DATE SIGNED M. D. TERY OR CREMATORY LOCATION (City, town, or county) (State
A15	EA	Burial 6 May 1955 Arlington	National Cemetery Arlington, Virginia
V.S.	PI	DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR 4 May 1955 May 6. Farrelly	R4. A. Funghrey Funeral Home Address 7557 Wisconsin Avenue, Bethesda, Md.

2221 6 YAM

1 4814			OF DEA	H—BALTIMORE, I	Dist. No. 215
				DENCE (HOME) OF DECE	
1. PLACE OF DEATH:					
COUNTY MONTGOMERY CITY (If outside corporate limits, write	MARYLAN		STATE DIS	trict of God umbi	AL and give nearest town)
OR and give nearest town) TOWN Bethesda Ru	(in th	ais place) 25 days	OR	hington, D.C.	47x-3
HOSPITAL OR INSTITUTION OR			STREET	(If rural give locs	
/ STREET ADDRESSU. S. Naval	Hospital		312	0 38th Street, N	
3. NAME OF (First) DECEASED:	(Middle)		Last)	4. DATE (Month)	(Day) (Year)
(Type or Print) Walton	Canby	FERE	OF BIRTH:	DEATH: MAY	9 19 55 DER 1 YEAR IF UNDER 24 HRO.
RACE: WIDO	owed, DIVORCED,		-2-00	54 yrs. Month	
OA. USUAL OCCUPATION (Give kind of work done during most of working life.	108. KIND OF BU	Y:		(State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
even if retired):U.S. GOVT	State Depar	rumenti	Pennsyl		1 05
Walter FERRIS			Hannah	PRICE	
is. Was Deceased Ever in U.S. Armed Force (Yes, no, or unk.) (If Yes, give war or dat	tes			å ADDRESS: Sarah FERRIS	
NO of service)	Unknown		Same as ab	ove	
		TENTIFICATI	ON		INTERVAL BETWEEN
I DISEASES OR CONDITIONS DIRECT				7 .	INTERVAL BETWEEN
DISEASES OR CONDITIONS DIRECT		EATH		maire	
237X	TLY LEADING TO D	EATH	Loma,	Braine	
IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY,	(A) DUE TO	EATH		Braine	
ANTECEDENT CAUSE (S)	(A) DUE TO (B) DUE TO	EATH		Baire	
IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(A) DUE TO (B) DUE TO (C)	EATH		Braine	
IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. II OTHER SIGNIFICANT CONDITIONS TO THE DEATH BUT NOT RELATED	(A)	EATH		Braice	
IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. II OTHER SIGNIFICANT CONDITIONS TO THE DEATH BUT NOT RELATED DISEASE OR CONDITION CAUSING	(A)	Lineg	Soma,	Baire	2 yu
IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. II OTHER SIGNIFICANT CONDITIONS TO THE DEATH BUT NOT RELATED DISEASE OR CONDITION CAUSING 19A. DATE OF OPERATION: 19B. MAJ 19334/1554	(A) DUE TO (B) DUE TO (C) CONTRIBUTING TO THE DOR FINDINGS OF	Lineg OPERATION	Soma,		20. AUTOPSY?
IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. II OTHER SIGNIFICANT CONDITIONS TO THE DEATH BUT NOT RELATED DISEASE OR CONDITION CAUSING 19A. DATE OF OPERATION: 19B. MAJ #334/454 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	(A) DUE TO (B) DUE TO (C) CONTRIBUTING TO THE DOR FINDINGS OF	Lineg OPERATION	Soma,	DID (City or town)	2 yu
IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. II OTHER SIGNIFICANT CONDITIONS TO THE DEATH BUT NOT RELATED DISEASE OR CONDITION CAUSING 19A. DATE OF OPERATION: 19B. MAJ 19334/1554	(A) DUE TO (B) DUE TO (C) CONTRIBUTING TO THE DOR FINDINGS OF 21B. PLACE (Hom OF INJURY street	OPERATION Le, farm, factor, office bldg., OCCURRED fot while	Joma, Jory, 21c. WHERE etc. INJURY OCC	DID (City or town)	20. AUTOPSY?
IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. II OTHER SIGNIFICANT CONDITIONS TO THE DEATH BUT NOT RELATED DISEASE OR CONDITION CAUSING 19A. DATE OF OPERATION: 19B. MAJ #334/454 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21D. TIME (Month) (Day) (Year) (Howo	(A) DUE TO (B) DUE TO (C) CONTRIBUTING TO THE DOR FINDINGS OF LEL LACE (Hom OF INJURY street (F) 21E INJURY While At work at work	OPERATION Le, farm, facte, office bldg., OCCURRED fot while the work	ory, 21c. WHERE etc. INJURY OCCI	DID (City or town) UR? INJURY OCCUR?	20. AUTOPSY? YES NO (County) (State)
IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. II OTHER SIGNIFICANT CONDITIONS TO THE DEATH BUT NOT RELATED DISEASE OR CONDITION CAUSING 19A. DATE OF OPERATION: 19B. MAJ 19A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21D. TIME (Month) (Day) (Year) (Hour OF INJURY 22. I hereby certify that I attended	(A) DUE TO (B) DUE TO (C) CONTRIBUTING TO THE G DEATH. JOR FINDINGS OF INJURY street TO THE A LEASE (Home OF INJURY while Not at work at the deceased from the deceased fr	OPERATION e, farm, factor, office bldg., OCCURRED fot while twork	ory, 21c. WHERE etc. INJURY OCCI. 21F. HOW DID une, 19 54 to .5 12:10M, from	DID (City or town) UR? INJURY OCCUR? May 19.55, that I the causes and on the	20. AUTOPSY? YES NO (State) (County) (State)
IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. II OTHER SIGNIFICANT CONDITIONS TO THE DEATH BUT NOT RELATED DISEASE OR CONDITION CAUSING 19A. DATE OF OPERATION: 19B. MAJ 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21D. TIME (Month) (Day) (Year) (Hour OF INJURY 22. I hereby certify that I attended alice on 9 May 19 55,	(A) DUE TO (B) DUE TO (C) CONTRIBUTING TO THE DOR FINDINGS OF 21B. PLACE (Hom OF INJURY street (C) While at work at the deceased from and that death of	OPERATION Le, farm, factor, office bldg., OCCURRED to while to work om 14 June	ory, 21c. WHERE etc. INJURY OCCI. 21f. HOW DID une, 19.54 to 12:10 M, from ADDRE	DID (City or town) UR? INJURY OCCUR? May 19.55, that I the causes and on the oss	20. AUTOPSY? YES NO (State) (County) (State) (last saw the deceased date stated above. DATE SIGNED
IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. II OTHER SIGNIFICANT CONDITIONS TO THE DEATH BUT NOT RELATED DISEASE OR CONDITION CAUSING 19A. DATE OF OPERATION: 19B. MAJ 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21D. TIME (Month) (Day) (Year) (Howo OF INJURY M. 22. I hereby certify that I attended alive on 9 May 19 55, W. MACKIE LCDR MC USIN 23. BURIAL, CREMATION, DATE THE	(A) DUE TO (B) DUE TO (C) CONTRIBUTING TO THE DOR FINDINGS OF LIE SPLACE (Hom OF INJURY street (C) CONTRIBUTING TO THE AT A LIE SPLACE (Hom OF INJURY street (C) CONTRIBUTING TO THE CONTRIBUTING TO THE CONTRIBUTING THE CONTRIBUTION THE CONT	OPERATION e, farm, facte, office bldg., OCCURRED to while to work The course at the course of t	ory. 21c. WHERE etc. INJURY OCCI. 21F. HOW DID une, 19 54 to 9 12: 10 An, from ADDRE	DID (City or town) UR? INJURY OCCUR? May, 19.55, that I the causes and on the ose	20. AUTOPSY? YES X NO (State) (County) (State) (last saw the deceased date stated above. DATE SIGNED
IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. II OTHER SIGNIFICANT CONDITIONS TO THE DEATH BUT NOT RELATED DISEASE OR CONDITION CAUSING 19A. DATE OF OPERATION: 19B. MAJ 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21D. TIME (Month) (Day) (Year) (Hour OF INJURY M. 22. I hereby certify that I attended alive on 9 May 19.55, TANNAMIPE R. W. MACKIE LCDR MC USIN 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation 11 May	(A) DUE TO (B) DUE TO (C) CONTRIBUTING TO THE DOR FINDINGS OF LIE SPLACE (Hom OF INJURY street (C) CONTRIBUTING TO THE AT A LIE SPLACE (Hom OF INJURY street (C) CONTRIBUTING TO THE CONTRIBUTING TO THE CONTRIBUTING THE CONTRIBUTION THE CONT	OPERATION e, farm, facte, office bldg., OCCURRED to while to work The course at the course of t	21c. WHERE etc. INJURY OCCI 21f. HOW DID 12:10AM, from ADDRE ad, NIMC, Beer or CREMATOF TO COUNTY Created the county of the	DID (City or town) UR? INJURY OCCUR? May 19.55, that I the causes and on the oss	20. AUTOPSY? YES X NO (State) (County) (State) (last saw the deceased date stated above. DATE SIGNED



)

CERTIFICATI	E OF DEATH Reg. Dist	. No. 216
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASE	D:
MANTINIMERY	STATE M.D. COUNTY MU	NTGOMERY
COUNTY MONTGOMERY MARYLAND CITY (If outside corporate limits, write RURAL LENGTH OF STAY)		
OR and give nearest town) (in this place)	TOWN SILVER SPRIN	
X TOWN BETHESDA. 12 Days	76 . 1 -1 . 1 -41-1	
HOSPITAL OR INSTITUTION OR SUBURBAN HOSPITAL	ADDRESS CRESTMOOR	CIRCLE.
3. NAME OF DECEASED: (First) A (Middle) Allen Rype or Print)	(Last) 4. DATE (Month) OF DEATH: MAY	Day) (Year) 25 19 55
5. SEX: 6. COLOR OR 7. SINGLE, MARRIED. 8. DATE	27/89 9. AGE last birthday Frunder 1 Months 1	Days Hours Min.
OA. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman	11. BIRTHPLACE (State or foreign country): 12.	COUNTRY?
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	
Felix 1 Instea	Fammie Phifer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:	
(Yes, no, or unk.) (If Yes, give war or dates of service)	213 Creatmor Circle, Sile	er Spring, m
18. MEDICAL CERTIFICA	TION	INTERVAL SETWEE
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		ONSE! AND DEA!
332 X	had Thrombosis	5 0145
DUE TO		
ANTECEDENT CAUSE (S)	and Atheros clerosis	142
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(260X) (C)		
TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	iabetes Mellitus.	
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION	N	20. AUTOPSY?
OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg		nty) (State)
21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRE While Not while at work		
22. I hereby certify that I attended the deceased from M.	ACA, 1955, to May, 25, 19 5 5 that I las	t saw the decease
alive on Man 25, 1955, and that death occurred a	ADDRESS , DA	stated above.
tames a. Coluts	M. D. 8907 Geo. Ave. Silver Spring, ma	. May 25, 1
	TERY OR CREMATORY LOCATION (City, town,	
1,000,000		ADDRESS S
DATE REC'D BY LOCAL BEGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR 4813 &	la ADDRESS no

481 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2361 18 YAM

BECEINED

LEASE

IF UNDER I YEAR IF UNDER 24 HRS. Months Days Hours (State or foreign country): 12. CITIZEN OF WHAT COUNTRY? 7 ONSET 20. AUTOPSY? NO (County) (State) 1953 to // (Ly) ..., 1953, that I last saw the deceased AM, from the causes and on the date stated above. SIGNATURE ADDRESS DATE SIGNED M. D. 2902 Porter St. 23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

(Day)

(Year)

19

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2391 9 YAN

Reg. Dist. No. 223-2. USUAL RESIDENCE (HOME) OF DECEASED CITY(If outside corporate limits, write RURAL and give nearest town) (If rural give location) (Month) (Dav) (Year) Months Hours BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT COUNTRY? INTERVAL BETWEEN ONSET AND DEATH 20. AUTOPSY (County) (State) 1967 that I last saw the deceased M, from the causes and on the date stated above. TE SIGNED (City, town, or county) (Statt)

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MARYLAND	STATE	DEPARTMENT	oF	HEALTH—PARTM	ORE,	18	047	9
4816		RTIFICATE				Dist		-

Reg. Dist. No

1. PLACE OF DEATH: 2. USUAL RESIDENCE (HOME) OF DECEASED: COUNTY Montgomery STATE Maryland COUNTY Montgome MARYLAND CITY (If outside corporate limits, write RURAL LENGTH OF STAY CITY (If outside corporate limits, write RURAL and give nearest town) OR and give nearest town)
TOWN (in this place) TOWN Silver Spring ver Spring HOSPITAL OR STREET (If rural give location) INSTITUTION OR ADDRESS 1014 Merrimac Drive 1014 Merrimac Drive STREET ADDRESS 3. NAME OF 4. DATE (Month) (Day) (Year) (Middle) (Last) (First) DECEASED: Newman Gaskins Corinne Hav (Type or Print) DEATH: 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX: 8. DATE OF BIRTH: S. COLOR OR 7. SINGLE, MARRIED, WIDOWED, DIVORCED, RACE: Months Days Hours Female (Specify): 3-29-1861 Widowed 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION. Give kind of 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country): COUNTRY? INDUSTRY: work done during most of working life, Orange, Virginia even if retired): U.S. Housewife 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME: James Newman Unknown 17. INFORMANT & ADDRESS: 15 WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY No.: (Yes, no, or unk.) | (If Yes, give war or dates of Daughter-Mrs. Dorothy P.Trayfors None 18. MEDICAL CERTIFICATION Interval Between 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO Onset And Death 450.0 Immediate cause (a) DUE TO Antecedent causes (s) Diseases or conditions, if any, (b) giving rise to the above cause DUE TO stating the underlying cause last. 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. AUTOPSY ? 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION Yes No 21. ACCIDENT (CITY OR TOWN) (COUNTY) (STATE) (Specify) PLACE (Home, farm, factory, street, SUICIDE OF office bldg., etc.) HOMICIDE INJURY TIME (Month) (Day) (Year) (Hour) INJURY OCCURED HOW DID INJURY OCCUR? While at Not While INJURY At Wo Work [19.25 that I last saw the deceased 22. I hereby certify that I attended the deceased from alive on // KL and that death occurred at from the causes and on the date stated above. SIGNATURE NAME OF CEMETERY OR CREMATORY & LOCATION (City, town, or county) BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF Cemetery Fauguier DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR

DECEIVED MAY 31 1955

24. FUNERAL DIRECTOR

8434 Ga. AVERESS Silver Spring.

VS. A15 -- 10 - 53

DATE REC'D BY LOCAL

REGISTRAR'S

BUREAU V.

2361 ES YAM

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4818

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1010	e e	
I. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY MONTONMERY MARYLAND	STATE Moryland COUN	MY Prince Deam
CITY (If outside corporate limits, write RURAL LENGTH OF STAY	CITY (If outside corporate limits, write RURAL a	nd give nearest town
TOWN (in this place)	TOWN Tayoma Dark	16-17-2
HOSPITAL OR	STREET (If rural give location)
STREET ADDRESS GO Fronk Robbins	ADDRESS 1306 Flower Ave	·
3. NAME OF DECEASED: (First) (Middle) G/en	(Last). Wright 4. DATE (Month) (Day OF DEATH: 5 - 20	p-Mayers
RACE: WIDOWED, DIVORCED,	OF BIRTH: 9. AGE last birthday: IF UNDER 1 Y 17 - 1868. 87 yrs. Months D	EAR IF UNDER 24 HRS. ays Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): // iner	R 11. BIRTHPLACE (State or foreign country): 12.	COUNTRY?
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	
Henry Glenwright	Mary Atkinson	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY No.: 17		06 Flower Cen
Yes, no, or unk.) (If Yes, give war or dates of service)	arol 6. Robbins, doughtergo	homa Dark no
18. MEDICAL CERTIFICATI	ION	Interval Between
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Onset And Deaf
334X Branche Phen	nou'la	3 DAYS
Immediate cause (a)	47.30.00.144	and the state of t
Antecedent causes (s) Diseases or conditions, if any,	LT. ER 10 SLEIZO SIS	5 YEARS
giving rise to the above cause stating the underlying cause last.	-1EK-1027-E18-021-2	92
I. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
9a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY ?
		Yes No
I. ACCIDENT (Specify) PLACE (Home, farm, factory, street office bldg., etc.)	(CITY OR TOWN) (COUNTY)	STATE)
TIME (Month) (Day) (Year) (Hour) INJURY OCCURED While at Not While INJURY m.	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5, 17-	.1955 to 5-30- 1955 that I last	saw the deceased
22. I hereby certify that I attended the deceased from 5	5-34-55 // From the source and on the date	stated above.
SIGNATURE (Degree or title)	ADDRESS D	ATE SIGNED
Them Gaig MN	8726 Colesville Rd Silver	SYCING MY
REMOVAL (Specify)	RY OR CREMATORY LOCATION (City, town, or co	ee. Penna.
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	24.) EVNERA DERICTORY	AMRESS VI
REGISTRAR Johnson Lotter	Softwar & alless 254 Garroll	201-01.11.
	+ SGakoma Ga	1 12, D.C.
	/apont	,

2361 AS YAM

BECEINED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4219

4819	CERTIFICAT	E OF	DEATH	Reg. Di	st. No. 211
I. PLACE OF DEATH:		2. USUA	L RESIDENCE (HOME		
COUNTY Montgomery	26.4 10.00	STATE	Maryland	60	UNTY Montg.
CITY (If outside corporate limits, wri	MARYLAND te RURAL LENGTH OF STAY		(If outside corporate lin		
X rowRural - Damascus	(in this place)	OR TOWN		Damascus	
HOSPITAL OR	19 months	STREE	ET (If rural give locati	
INSTITUTION OR STREET ADDRESS R.F.D. #	3 Mt. Airy	ADDR	R.F.D.	#3 Mt. A:	lry
3. NAME OF (First)	(Middle)	(Last)	4. DATE	(Month) (I	Day) (Year)
(Type or Print) Mary		obble	DEATH:	May 2	23 19 55
RACE: WID	OOWED, DIVORCED,	of BIRTH:		yrs. Months	Days Hours Min.
10a. USUAL OCCUPATION. Give kind of	10b. KIND OF BUSINESS O	R II. BIRT	THPLACE (State or for	eign country): I	2. CITIZEN OF WHAT
work done during most of working life, even if Heirbewife	INDUSTRY: Own Home	Sne	edville. Te	nn.	USA
13. FATHER'S NAME:			ER'S MAIDEN NAME:		
Andrew J. Orick		Mar	tha Buckles		
15 WAS DECRASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates	of	. INFORMA	NT & ADDRESS:		202
NO service)			. Gobble, M	t. Alry,	Md.
I. DISEASES OR CONDITIONS DIRECT	18. MEDICAL CERTIFICAT	ION			Interval Betwee
502.0	B + . O	x.	1. 0.	1.	Onset And Deat
Immediate cause	(a) Churioselin	Tuc Cu	yeur oderno	ouslase	I years.
Antecedent causes (s) Diseases or conditions, if any,	(a) arteriosalus (b) Chinic browch E TO	iti x	emphysem	X	7 years
	(c)				
 OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but related to the disease or condition causi 					
19a. DATE OF OPERATION: 19b. MAJO	OR FINDINGS OF OPERATION				20. AUTOPSY ?
N ACCUPANT			AD	(COTITION)	Yes No
HOMICIDE OF	JURY	t, (CITY	OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	While at Not While	HOW DI	D INJURY OCCUR?		
22. I hereby certify that I attended	the deceased from 2 2	,1951,	toMay 53, 19	55., that I la	st saw the deceased
alive on May 13, 1955, an					
Lamas, sur	NA.M	Nan	M. curren	1 5	159155
23. BURIAL, CREMATION, DATE THE REMOVAL (Specify) May 2	6.1955 Pleasa			N (City, town, or ovia, Fre	county) (State)
DATE REC'D BY LOCAL REGISTRAL	R'S SIGNATURE		L. Moleswor	th, Damas	scus, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE. 18 (148) CERTIFICATE OF DEATH 4760 2. USUAL RESIDENCE (HOME) OF DECEASED 1. PLACE OF DEATH: COUNTY OF Montgomery MARYLAND CITY(If outside corporate limits, write RURAL and give nearest town) CITY (If outside corporate limits, write RURAL) LENGTH OF STAY (in this place) OR and give nearest town) TOWN lakoma STREET (It rural give location) HOSPITAL OR INSTITUTION OR ADDRESS STREET ADDRESS (Last) (Year) 3. NAME OF DECEASED Charles 19 55 (Type or Print) Drantham DEATH: DATE OF BIRTH: 9. AGE last birthday IF UNO HE I YEAR COLOR OR 17. SINGLE, MARRIED WIDOWED, DIVORCED. (Specify): Married 10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY3 work done during most of working life. OR INDUSTRY: even if retired): M153,55. PPI 14. MOTHER'S MAIDEN NAME: 13. FATHER'S NAME: Shaws Dona 17. INFORMANT & ADDRESS: 18. SOCIAL SECURITY NO. (Yes, no, or unk.) (If Yes, give war or dates San of service) will Y 18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH ONSET AND DEATH MMEDIATE CAUSE DUE TO ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Recent In

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH 19A. DATE OF OPERATION: 198. MAJOR FINDINGS OF

218. FLACE (Home, farm, factory, 21c. WHERE DID (City or town) OR CONTRIBUTING CAUSE OF DEATH OF INJURY Street, office bldg., etc. INJURY OCCUR?

(County) (State)

21E INJURY OCCURRED
While Not while
at work at work 21D. TIME (Month) (Day) (Year) (Hour) OF TNJURY

21A. ACCIDENT-WAS UNDERLYING

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21F. HOW DID INJURY OCCUR?

, to 5-3-55, 19 ..., that I last saw the deceased 22. I hereby certify that I attended the deceased from 4.25.55-19. alive on 5-3-5-5, 19..., and that death occurred at /1 15 M, from the causes and on the date stated above. DATE SIGNED (State)

NAME OF CEMETERY OR 23. BURIAL CREMATION. REMOVAL (SPECIFY)

LOCATION (City, town, or county)

ADDRESS

LOCAL I

DECEIVED

My Silver Spring.

2361 SI YAM

BUREAU V. S.

STATEMENT OF THE WAY OF THE PARTY STATEMENT OF THE PARTY OF THE PARTY

THE RESERVE THE PROPERTY OF THE PARTY OF THE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2 17

	aseg. Dist. III	V • · · · · · · · · · · · · · · · · · ·
1. PLACE OF DEATH-	2. USUAL RESIDENCE (HOME) OF DECEASED.	v
montgomery Maryland	Maryland mont	Tanmery
OR give nearest town) (in this place)	CITY (If outside corporate limits, write RURAL and given	vs nearest town)
TOWN Sandy Soring (in this place)	TOWN Sandy SAPING.	X
HOSPITAL OR	STREET (If rural, give location)	1
INSTITUTION OR STREET ADDRESS	ADDRESS	1
3. NAME OF (First) (Middle) DECEASED	(Last) 4. DATE (Month)	(Day) (Year)
(Type or Print) Herbert Lee	Harding DEATH IVIAY	16 1955
6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED,	8. DATE OF BIRTH 9. AGE last birthday If under Months	1 year If under 24 hrs Days Hours Min.
M. (Specify) married	1 48 1887 65 ym.	Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work 10b. Kind of Business or done during most of working life, even if retired) INDUSTRY	11. BIRTHPLACE (State or foreign country)	2. CITIZEN OF WHAT COUNTRY?
Carpenter- Retired	mary and.	MSA
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
Granville Harding	Catherine Williams.	
15. WAS DECRASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS	1 0 1
(Yes, no, or unknown) (Il yes, give war or dates of 213-05-8588	Mrs. Herbert Harding San	dy Sarine had
18. MEDICAL CEI		1 117
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN
	- [- [- [- [- [- [- [- [- [- [ONSET AND DEATH
Immediate cause (a) Coronary	hrom bosis	15 mm.
Diseases or conditions, if any, (b) 174 per 1873. Use giving rise to the above cause stating the underlying cause last (c) 11. OTHER SIGNIFICANT CONDITIONS	Cardio Vascular Disease	75.
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
		Yes \ No \
21. ACCIDENT (Specily) PLACE (Home, farm, factory, street,	(CITY OR TOWN) (COUNTY)	
SUICIDE OF office bldg., etc.) HOMICIDE INJURY		,
TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED	HOW DID INJURY OCCUR?	
OF INJURY m. While at Not While Work At work		
	411 111 411	
22. I hereby certify that I attended the deceased from 22	-, 1955, to 5/14, 1955, that I last s	aw the deceased
5/14/ 55 8	300	
	ADDRESS and on the date st	ated above.
SIGNATURE: (Degree or title)	ADDIVESS	DATE SIGNED
HILL	Dandy Son me Man.	1 and 1/18/
23. BURIAL, CREMATION Y DATE THEREOF NAME OF CEMETER	RY OR CREMATORY LOCATION (City, town, or coun	
REMOVAL (Specify) May 19165	Tensalletten montes on	ma
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	24 FUNERAL DIRECTOR	ADDRESS
REG. 12 12/12 12 1	Rod W Bash X and T	i l'An in-
.7 - 19 - 3 6 - Wellmade of Lawren	word of the state	er y

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

The correct age

VS. A15

23 1955 YAM

MECEINED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The

S. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIM	ORE, 18
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CERTIFICATE OF DEATH

E,	18	0	180,8)
Rog	Diet	No	2/6	

1. PLACE OF DEATH:	2	. USUAL RESID	ENCE (HOME) OF DECE	ASED:
COUNTY Montgomery MARY	LAND	STATE Mary	land county Mo	ntgomery
CITY (If outside corporate limits, write RURAL LEN	GTH OF STAY	CITY(If outside	corporate limits, write RUR	AL and give nesrest toy
\/ TOUGH	n this place)	OR TOWN TOO	in the way	V
A De one sua	days	STREET	aton (If rural give loca	tlon) /
INSTITUTION OR THE CELLILICAL CENTER	r	ADDRESS		
30 STREET ADDRESS National Institutes	of Health	11701	Grandview Avenu	e
3. NAME OF (First) (Middle)	(Las	st)	4. DATE (Month)	(Day) (Year)
DECEASED: (Type or Print) Rosanna	Harns		OF DEATH: MAV	1 1955
5. SEX: 6. COLOR OR 7. SINGLE, MARRIED.	8. DATE OF	BIRTH:	9. AGE last birthday IF UND	
Female White Specify: Married	D. October 9	3000	3), yrs. Month	s Days Hours Mi
Female White (Specify): Married	October 8		24	110 01717711 07 1111
	STRY:	. BIRTHPLACE	(State or foreign country):	COUNTRY?
even if retired):Housewife Ow	n Home	Pennsylv	ania	U.S.A.
13. FATHER'S NAME:	1	4. MOTHER'S M		
Tarank Maranaira		Tless I Amm		
Joseph Musgrove	FCURITY No. 1	Hazel Amm		
(Yes, no, or unk.) (If Yes, give war or dates Non			a //DD/(LOO).	
LI No of service) Not Ave	ilable Th	e medical	record, The Clin	ical Center
	L CERTIFICATION			INTERVAL BETWE
I DISEASES OR CONDITIONS DIRECTLY LEADING TO	DEATH	4		ONSET AND DEA
204.0	1.	111.1	is linking	is
IMMEDIATE CAUSE (A)	upe my	mary by	a aujum	a 3 ma
ANTECEDENT CAUSE (S)		0		
DISEASES OR CONDITIONS, IF ANY, (B)				
STATING UNDERLYING CAUSE LAST. DUE TO				
(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING	3		/	
TO THE DEATH BUT NOT RELATED TO THE	La shill as	0/55110 10	wren septe	Earne &
DISEASE OR CONDITION CAUSING DEATH.		0.000,00	The contract of the contract o	viii von
19A. DATE OF OPERATION: 198. MAJOR FINDINGS	OF OPERATION			20. AUTOPSY
				YES NO
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (HOOR CONTRIBUTING CAUSE OF DEATH OF INJURY str	lome, farm, factory,	21c. WHERE		County) (State)
OR CONTRIBUTING CAUSE OF DEATH OF INJURY STE	eet, office bldg., etc.	INJURY OCCL	IR?	
21p. TIME (Month) (Day) (Year) (Hour) 21E INJUR	Y OCCURRED	21F. HOW DID	INJURY OCCUR?	
OF INJURY While	Not while at work			
22. I hereby certify that I attended the deceased	from Mar. 2	., 195.5., to M	ayl, 19.55, that I	last saw the deceas
alive on May/ 1 , 1955 , and that death	occurred at 6	A M from t	he causes and on the d	ate stated shove
SIGNATURE	occurred at 6	ADDRES	SS	DATE SIGNED
Horace W. Durnte	m - un	The Clini	s cal Center Institutes of He	-1+h
	ME OF CEMETERY	OR CREMATOR	Y LOCATION (City, tow	n, or county) (Sta
REMOVAL (SPECIFY)				
LOCAL J. Chile	klawn Cemet		Rockville Pike	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATUR	E	24 FUNERAL	CO LA CELL	ADDRESS

DECEIVED MAY 6 1955

UNFADING INK. Supply every item of information carefully. The correct Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH

MARYLAND STATE DEPARTMENT OF HEALTH—BASSAMULE.

CERTIFICATE OF DEATH

114804 Reg. Dist. No.

I. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:
COUNTY Montgomery MAR	RYLAND STATE Maryland county Montg.
CITY (If outside corporate limits, write RURAL LENGT	TH OF STAY CITY (If outside corporate limits, write RURAL and give nearest town)
X TOWN Cabin John (in	this place) OR TOWN Cabin John
HOSPITAL OR	STREET (If rural give location)
INSTITUTION OR STREET ADDRESS 6424-79th St.	ADDRESS 6424-79th St.
3. NAME OF DECEASED: (First) (Middle) (Type or Print) MYRTLE A	HILL (Last) 4. DATE (MAY) 19 (Day) 1955 (Year) DEATH: MAY 19 (1955) 19
emale S. COLOR OR RACE: Widowed, Divorces (Specify): Marrie	p, 8. DATE OF BIRTH: D, June 30,1888 9. AGE last birthday: If UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, INDUSTRY	BUSINESS OR 11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT
even if retired): Housewife Housey	Consulation National Life
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
William T. Redden	Isabelle Pennfield
15 WAS DECEASED EVER IN U.S. ARMED FORCES! 16. SOCIAL SECU	URITY No.: 17. INFORMANT & ADDRESS:
(Yes, no, or unk.) (1f Yes, give war or dates of service) None	Husband - 6424-79th St. Cabin John, Md.
1	CERTIFICATION Interval Betwee
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO	earcinema J. sebacceun gland 2 years left check with multiple aslastis and & lung acgist
	aslassis and to engling
 OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 	
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF	and a Applicate Court
21. ACCIDENT (Specify) PLACE (Home, farm, office bldg.,	factory, street, (CITY OR TOWN) (COUNTY) (STATE)
HOMICIDE	
OF While at	Not While At Work
22. I hereby certify that I attended the deceased fr	om 6 30 - 1954, to WAI 18 1905, that I last saw the deceased
	1/10/24
alive on MAY 18, 1955, and that death A	ADDRESS AND WATE SIGNED
SIGNATURE Washington Washington	St., N. W. ADDRESS MAY 19 1055
23. BURIAL, CREMATION, DATE THEREOF NAME REMOVAL (Specific)	St., N. W. ADDRESS MAY 19 1955
23. BURIAL, CREMATION, DATE THEREOF NAME REMOVAL (Spetity) 5 23/55 Pa	St., N. W. ADDRESS MAY 19 1955 BELLEVILLE OF CREMATORY LOCATION (City, town, or county) (States) Relation MAY 19 1055 Relation MAY 19 1055 Relation MAY 19 1055
23. BURIAL, CREMATION, DATE THEREOF NAME REMOVAL (Specify)	St., N. W. ADDRESS MAY 19 1955

BECEINED

BUREAU V. S.

2261 PS YAM

MARYLAND	STATE	DEPARTMENT	OF	HEALTH-	BALTI	MORE,	18
		TATEL ACT	MACON TO	AUTTITO A	FINANCE	OTT	TAT

()	A	01	1	F.	
Re	7	Di	St	U	

MEDICAL EXAMINER'S CER	TIFICATE OF DEATH No
4. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:
COUNTY Montgomery MARYLAND	STATE MA COUNTY Minly
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN CITY (If outside corporate limits, write RURAL (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Germania
HOSPITAL OR INSTITUTION OR R. F. J. # 2	STREET ADDRESS R FU (If rural, give location) /
3. NAME OF DECEASED: (First) (Middle) (Type or Print) (Villiams)	How DEATH May 5 1955
Mile RACE: WIDOWED, DIVORCED, Specify): Married Stop	F OF BIRTH: 9. AGE last birthday: F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work dene during most of work life, even in retried).	maryland O'SIA
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY No.: (Yes, no, or unk.) (If Yes, give war or dates of strike) way	Wooden Hoes, Germantown, md
	CAL CERTIFICATION INTERVAL BETWEE
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:	ONSET AND DEATH
Immediate cause	ecclusion Formel
Antecedent cause(s)	No of
Diseases or conditions, if any, (b)	Jest 0
giving rise to the above cause DUE TO	This begroon
stating underlying cause last (c) II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING	
TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION;	20. AUTOPSY? Yes \(\subseteq \text{No } \(\subseteq \)
21a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. 21b. PLACE (Home, farm, factor OF street, office bldg., et INJURY	Co,
21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED While at Not while iNJURY M. work at work	
22. I hereby certify that I took charge of the remains descr	ibed above, held an Autopsy [], Inspection [], Inquiry [], ar
find that death resulted from: Natural causes , Acc	ident [], Suicide [], Homicide [], Undetermined cause [CHIEF MEDICAL EXAMINER [] DATE SIGNED
Thank O Broschart	M. D. ASSISTANT MEDICAL EXAMINER 5-5-55
23, BURIAL, CREMATION, DATE THEREOF NAME OF GEMETE REMOVAL (Specify): Way 8, 1955	CRY OR CREMATORY LOCATION (City, fown, or county) (State)
DATE REC'D BY LOCAL REGISTRAN'S SIGNATURE REG. 5/4/5-5 Tauxel & Krastors	24. FUNERAL DIRECTOR RESPONDENCE PROPERTY ADDRESS

VS. A15A - 5 - 53

Ozi.

DEVEDER NAMED 1955

BUREAU V. S.

VS.

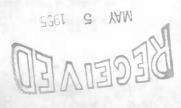
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4825 CERTIFICATE OF DEATH

Reg. Dist. No. 274

1. PLACE OF DEATH:		2. USUAL RESID	DENCE (HOME) OF DECE	ASED:
COUNTY Montgomery	MARYLAND	STATE Virg	rinia COUNTY A	lexandria
CITY (If outside corporate limits, write R	URAL LENGTH OF STAY	CITY(If outside	corporate limits, write RUR	
OR and give nearest town)	(in this place)	OR TOWN AT	exandri a	83 x 3
/\ bethesua	13 days	STREET	(If rural give locat	tion)
AS INSTITUTION OF THE GITTI CAL	Center	ADDRESS		
STREET ADDRESS National Inst.	itutes of Health		5 N. Alfred Stre	
3. NAME OF (First) DECEASED:	(Middle)	(Last)	4. DATE (Month)	(Day) (Year)
(Type or Print) Lydia	Belle v H	lolmes	DEATH: May	1 1955
5. SEX: 6. COLOR OR 7. SINGLE, WIDOWE (Specify)	D, DIVORCED.	OF BIRTH:	9. AGE last birthday Ir under Months	
Female Negro	Married January	12, 1931	(State or foreign country):	
OA. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	B. KIND OF BUSINESS OR INDUSTRY:			12. CITIZEN OF WHAT COUNTRY?
Housewife		North Carol	ina	U.S.A.
13. FATHER'S NAME:		14. MOTHER'S N	TAIDEN NAME:	
John Evans		Roberta Whi	tehurst	
15, WAS DECEASED EVER IN U.S. ARMED FORCES?	16. SOCIAL SECURITY NO.	17. INFORMANT	& ADDRESS:	
(Yes, no, or unk.) (If Yes, give war or dates of service)	Not Available	The medical	record, The Cli	nical Center
	IS. MEDICAL CERTIFICAT	ION		INTERVAL BETWEEN
I DISEASES OR CONDITIONS DIRECTLY	LEADING TO DEATH			ONSET AND DEATH
7544	(A) Congenital	heart diseas	se	
MMEDIATE CAUSE	DUE TO Hydroperica		,6	
ANTECEDENT CAUSE (3)			and liver	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE		of the lungs		
STATING UNDERLYING CAUSE LAST.	OUE TO Partially h	septal defe	ect patent	
II OTHER SIGNIFICANT CONDITIONS CO	NTRIBUTING Partial	y healed sur	'gical incision o	4.
TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING DE	THE Fibrous adhes	ions about t	he Fallopian tub	es
DISEASE OR CONDITION CAUSING DI	FINDINGS OF OPERATION	over the si	nll_intestines	
				20. AUTOPSY?
4-21-55 Inter	atrial septal def	.ect		YES NO
21A. ACCIDENT WAS UNDERLYING 21 OR CONTRIBUTING CAUSE OF DEATH OF	B. PLACE (Home, farm, fact FINJURY street, office bldg.,	etc. INJURY OCCU		County) (State)
21D. TIME (Month) (Day) (Year) (Hour)	21E INJURY OCCURRED	21F. HOW DID	INJURY OCCUR?	
OF INJURY M.	While Not while at work			
22. I hereby certify that I attended th	e deceased from April	18 1955. to Ma	v. 1. 1955, that I	last saw the deceased
alive on May 1, 1955 , and				
SIGNATURE , 1935., and		ADDRE	SS	DATE SIGNED
Hedrow D. V.	Nonow M	The Clini	Cal Center Institutes of He Y LOCATION (City, town	5/2/55
23. BURIAL, CREMATION, DATE THEREO	OF NAME OF CEMETI	ERY OR CREMATOR	Y LOCATION (City, town	alth J/~/ JJ n, or county) (State)
REMOVAL (SPECIFY)	- 100 +	nati	Callint	11
[Julia] ~ 1813 S	urlington		non marian	Va
DATE REC'D BY LOCAL REGISTRAR'S	SIGNATURE	24. FUNERAL	0 1 1 1 1 1	ADDRESS
3/2/50 17 esace	M. Lhomkson	a.li - Jewy	, 800 Walte	St. alex. Va



7. The	4826 CERTIFICATI	E OF DEAT		eg. Dist. N	. 215
ully.	1. PLACE OF DEATH:	2. USUAL RESIDEN	NCE (HOME) OF D	ECEASED:	
carefull legibly.	COUNTY Montgomery MARYLAND	STATE Virg	inia COUNTY		
ca l le	CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) (in this place)		orporate limits, write	RURAL and	give nearest town)
tion	XTOWN Bethesda Rural 2 hrs 33 min		andria	8.	3 X - 3
ly ily	HOSPITAL OR	STREET ADDRESS	(If rural give	location)	
m of informa	5/STREET ADDRESS U. S. Naval Hospital		North Overlo	ok Drive	2
in h	3. NAME OF (First) (Middle) DECEASED:	(Last)	4. DATE (Mont		
or	(Type or Print) Douglas (n)	HOUSER	DEATH: Ma		1955
ite of	5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single 5-30-		. AGE last birthday III	fonths Days	
causes	10A. USUAL OCCUPATION (Give kind of work done during most of working life, oR 1NDUSTRY:	11. BIRTHPLACE (S		y): 12. CIT CO	IZEN OF WHAT
oly e c	13. FATHER'S NAME:	Bethesda,	MAT Y LALIO		US
upply the	William D. HOUSER	Potty T	LIODID AT T		
	15. WAS DECEASED EVER IN U.S. ARMED FORCEST 18. SOCIAL SECURITY NO.	Betty L.	ADDRESS:		
	(Yes, no, or unk.) (If Yes, give war or dates None	Same as abo	William D. H	OUSER	
	18. MEDICAL CERTIFICAT			IN	TERVAL BETWEEN
ZI d	I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	1		01	SET AND DEATH
AD s:	IMMEDIATE CAUSE (A) PRIMAT	unite		2	hr 33 min
TH UNFADING Physicians: plea	ANTECEDENT CAUSE (S)	7			
	DISEASES OR CONDITIONS, IF ANY, (B)			100	
TH.	GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST.				
H	(C)				
• 6	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE				
NL	DISEASE OR CONDITION CAUSING DEATH.	<u> </u>			
4	Date of Operation: 198. MAJOR FINDINGS OF OPERATION	N			ZO. AUTOPSY?
	21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, factor CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., (if either, notify medical examiner)	etc. INJURY OCCUR	D (City or town)	(County)	(State)
>	21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while at work at work	21F. HOW DID IN	JURY OCCUR?		
OH	22. I hereby certify that I attended the deceased from30 1	May, 1955, to 30	May, 1955, th	at I last sa	w the deceased
E SE	alive on 30 May , 1955 , and that death occurred at				ted above.
SE TYI	6/10 = /1 00				
PLEASE	23. BURAL AMENATION, NOAVE THEREOF U. NAME OF SAME				
LE	Burial 8 June 1955 Arlington	National Cemet	ery Arlingt	on, Vir	ginia ODRESS
Д.	DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR 2 June 1955 Day 6 Famely	Cunningham Alexandria,	Funeral Home Virginia		DUNESS
			The second second		

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VS. A15 -- 10 - 53

MARYL	AND STATE	DEPARTMENT	OF H	IEALTH—BA	LTIMORE,	1
4827	June 19	A- +22 FILM	G 324	1 10/23/62	- Jus	
2 0 /0 6	CE	RTIFICATE	OF	DEATH	Reg.	T

MARYLAND STA	ATE DEPARTMENT OF STIFICATION	T OF HEAL' E OF DEA	TH—BALTIMORE, 18 0/23/62 Jun Reg. D	3 048086 ist. No. 296
1. PLACE OF DEATH:		2. USUAL RES	IDENCE (HOME) OF DECEA	SED:
COUNTY Montgomery	MARYLAND	STATE W	Virgini@ounty	
CITY (If outside corporate limits, write RI	URAL LENGTH OF STAY		de corporate limits, write RURA	L and give nearest town)
OR and give nearest town) TOWN Bethesda	(in this place)	OR	Belle, West Virgini	0
HOSPITAL OR The Clinical STREET ADDRESS National Trest		STREET ADDRESS	(If rural give location	on)
. Ivacional inst	citates of Health		1831 West Dupont	V
3. NAME OF (First) DECEASED:	(Middle)	(Last)	4. DATE (Month)	(Day) (Year)
(Type or Print) Dana	M. Huddle		DEATH: May	10 19 55
5. SEX: 6. COLOR OR 7. SINGLE. WIDOWEL (Specify):	MARRIED. D. DIVORCED. Single 6 Dec.	of BIRTH:	9. AGE last birthday IF UNDER Months	
IOA. USUAL OCCUPATION (Give kind of 10B.	KIND OF BUSINESS		(State or foreign country): 1	2. CITIZEN OF WHAT
work done during most of working life,	OR INDUSTRY:			COUNTRY?
Nut Se	representa	West Virg		USA
13. FATHER'S NAME:		14. MOTHER'S	MAIDEN NAME:	
John Huddleston		Georgia	Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES?	16. SOCIAL SECURITY NO.	17. INFORMAN	T & ADDRESS:	
(Yes, no, or unk.) (If Yes, give war or dates of service) W. W.	none	The modian	l record, The Clin	inal Conton
	none		I record, The CILI	
I DISEASES OR CONDITIONS DIRECTLY L	B. MEDICAL CERTIFICAT EADING TO DEATH	ION		INTERVAL BETWEEN
ANTECEDENT CAUSE (\$) DISEASES OR CONDITIONS, IF ANY.	UE TO Epidermoid		f right maxillary hrough to cranial	cavity
	(C)			
II OTHER SIGNIFICANT CONDITIONS CONTO THE DEATH BUT NOT RELATED TO T	TRIBUTING			
DISEASE OR CONDITION CAUSING DE.	ATHFINDINGS OF OPERATIO	N		
Profest Silv	d carcinoma of f		ary sinus.	YES NO
OR CONTRIBUTING CAUSE OF DEATH OF	. PLACE (Home, farm, fac INJURY street, office bldg.,	tory. 21c. WHERE etc. INJURY OCC	COR7 (City or town) (Co	unty) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	While Not while at work at work	21F. HOW DIE	O INJURY OCCUR?	
22. I hereby certify that I attended the				
alive on May 10 , 1955 , and SIGNATURE	Ditturan !	3.00 The ADDRI	hical Center Institutes of Healt	h May 10,1955
BURIAL (SPECIFY)	5 MONIGOM	ERY MEM. P	ARK LONDON, 1	V. VA.
DATE REC'D BY LOCAL REGISTRAR'S REGISTRAR'S	M Shomkson	24. FUNERAL	Hines Co, vi	ADDRESS
The state of	The war dear	7//	runes to, u	asking by 7, 0



2361 91 YAM

SIGNATURE

Bethesda, Md.

DATE REC'D BY LOCAL

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DII	ply
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M	K,

MARYLAND S	STATE	DEPARTMENT	OF	HEALTH—BALTIMORE,	18
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04810

4829 MARYLAND STATE DEPARTMENT CERTIFICATE		04810
Item 9. FilmGl81 5-18-55 et	OF DEATH Reg. Dist.	No. ~ 12
	2. USUAL RESIDENCE (HOME) OF DECEASED	:
COUNTY Montgomery MARYLAND	STATE DC COUNTY	
CITY (If outside corporate limits, write RURAL (in this place) OR and give nearest town) Y TOWN Bethesda Rural CENGTH OF STAY (in this place) 2 Mos.14 da.	CITY(If outside corporate limits, write RURAL a OR TOWN Washington	nd give nearest town
HOSPITAL OR INSTITUTION OR	STREET (If rural give location) ADDRESS	1
5/ STREET ADDRESSU.S. Naval Hospital	Westchester Apts	V
DECEASED: (Type or Print) William Lambert Hu	aggins Jr. OF DEATH: May 7	(Year) 1955
	or 1902 9. AGE last birthday 1F UNDER 1 Y Months D	
	11. BIRTHPLACE (State or foreign country): 12. Kansas	CITIZEN OF WHA
	14. MOTHER'S MAIDEN NAME:	
William L. HUGGINS	Emma SPOHR	
(Yes, no, or link.) (If Yes, give war or dates of service) 2/12 = 9/15	Son: William L. HUGGINS 504 W Oreland	Garden Rd.
18. MEDICAL CERTIFICATIO		INTERVAL BETWEE
237% IMMEDIATE CAUSE ANTECEDENT CAUSE (S) IN DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH (A) DIAM TUMOT DUE TO	, left cerebraum	7 month
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO		
(C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING		
TO THE DEATH BUT NOT RELATED TO THE		
DISEASE OR CONDITION CAUSING DEATH. 19A, DATE OF OPERATION: 19B, MAJOR FINDINGS OF OPERATION		
28 Dec 19543 No evidence of tumos		YES NO
21a. ACCIDENT WAS UNDERLYING ☐ CAUCHO OR CONTRIBUTING ☐ CAUCE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) OF INJURY Street, office bldg., et	ry, 21c. WHERE DID (City or town) (Count tc. INJURY OCCUR?	y) (State)
OF INJURY (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while at work	21F. HOW DID INJURY OCCUR?	5 1135
22. I hereby certify that I attended the deceased from 23. Feb	o, 1955, to7May, 1955, that I last	saw the decease
	5:25 M, from the causes and on the date	
E.P. THELEN LCDR MC USN U.S. Naval Hospita M. C. 23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETER REMOVAL (SPECIFY)	P. NNMC Bethesda Maryland 7 Mary or Crematory Location (City, town, or	Eounty) (State
Burial 5-10-55 Arlington Nat		ia
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR 3072 M S Chambers Funeral Home, Washing	ADDRESS

. The particular

2361 91 YAM

BECEINED

* M	f information carefully. The
MARGIN RESERVED FOR BINDING	PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
MARGIN RESE	TE PLAINLY, WITH UNF.
3. A15 — 10 - 53	PLEASE TYPE OR WRI'

4830 CERTIFICA	Reg. Dist. No.				
I. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:				
COUNTY Montgomery MARYLAND	STATE Virginia COUNTY Loudoun				
CITY (If outside corporate limits, write RURAL) LENGTH OF					
OR and give nearest town) TOWN Bethesda Rural (in this plays)	OR TOWN Round Hill 83 4 - 3				
HOSPITAL OR	STREET (If rural give location)				
5 STREET ADDRESS U. S. Naval Hospital	ADDRESS				
3. NAME OF (First) (Middle)	(Last) 4. DATE (Month) (Day) (Year)				
DECEASED: (Type or Print) Arthur (n)	NGERSOLL DEATH: May 21 19 55				
5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. RACE: WIDOWED, DIVORCED,	ATE OF BIRTH: 9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10. 20.	24-67 88 yrs. Months Days Hours Min.				
IOA. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINE	S 11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT				
work done during most of working life, even if retired): Retired School Teacher	Massachusetts U. S.				
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:				
Thomas Ingersoll	Mehitable Waterhouse				
(Yes, no, or unk.) (If Yes, give war or dates	Son Stuart H INGERSOLL				
No of service) None	Same as above				
IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	hopmennonia, organism unhuour Zweltze				
194. DATE OF OPERATION: 198. MAJOR FINDINGS OF OPER	TION 20. AUTOPSY?				
0	YES NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office (IF EITHER, NOTIFY MEDICAL EXAMINER)	, factory, oldg., etc. INJURY OCCUR? (County) (State)				
OF INJURY (Month) (Day) (Year) (Hour) 21E INJURY OCCU While Not wh at work at work					
22. I hereby certify that I attended the deceased from	13 May, 1955, to 21 May, 1955, that I last saw the deceased				
	d at 10:25 M, from the causes and on the date stated above.				
P. G. BAMBERG LT MC USN P.9. Bawleen	M.U.S. Naval Hospital, NNMC, Bethesda, Md.				
23. BURIAL, CREMATION, DATE THEREON NAME OF C	METERY OR CREMATORY LOCATION (City, town, or county) (State)				
Of China of China	l Crematory Prince George Co, Maryland				
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR 23 May 1955 Pary 6 tarre	24. FUNERAL DIRECTOR R. A. Pumphrey Funeral Home 7557 Wisconsin Ave. Bethesda, Marylan d				

-10 - 53A15 VS.

2361 9S YAM

BECEINED

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—B	ALTIMORE, 1804812
4831 CERTIFICATE OF DEATH	Reg. Dist. No. 2/3
Ttem 7, FilmG182 6-7-55 et	
1. PLACE OF DEATH: 2. USUAL RESIDENCE (I	HOME) OF DECEASED:
COUNTY Moregomeny MARYLAND STATE Mary	COUNTY Monlap.
OR and sive pearest town (in this place) OR	rate limits, write RURAL and give neares town
Land Davider 18 des 10 mg	erlawy x
INSTITUTION OR STREET ADDRESS A	(If rural give location)
STREET ADDRESS Harring # 3 Nach	where , 1617. 10. #3
3. NAME OF (First) (Middle) (Last) 4. DA	
(Type or Print) HARKY	EATH: 12 31, 19 33
6. SEX: 6. COLOR OR 7. SINGLE, MARRIED, WIDOWED, DIVORCED, May 30, 1893	dest birthday: If under 1 YEAR IF UNDER 24 HRS. Mon hs Days Hours Min.
work done during most of working life, INDUSTRY:	or foreign country): 12. CITIZEN OF WHAT
13. FATHER'S NAME:	AT A CONTRACTOR OF THE PARTY OF
John Hoper	purger
15 WAS DECEASED EVER IN U.S. ARMED FORCE ? 16. SOCIAL SECURITY NO.: 17. INFORMANT & ADDRESS (Yes, wo, or unk.) (If Yes, give war or dates of service)	oppy.
18. MEDICAL CERTIFICATION	1 140
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	Interval Betwee Onset And Deat
Immediate cause (a) DUE TO	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO	3 - years
(c)	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, (CITY OR TOWN)	Yes No No (COUNTY) (STATE)
SUICIDE OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) INJURY OCCURED While at Not While Not Work At Work	
22. I hereby certify that I attended the deceased from 19 way, 19 55, to 31 w	19.55, that I last saw the deceased
	causes and on the date stated above.
23. HEAL, CREMATON, DATE THEREOF NAME OF CEMETERY OR CREMATORY	CATION (City, town, or contry) (State)
Situate (Specify) 6/2/3 I Finerta Pack	Rochville, ma
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR 6/2/55 January M. Kannap B. Will H. Annuar B. Will H. Will H. W. Will H. W. Will H. W. Will H. W.	when Rockvelle,
	md
	7

DECEN

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg.	Dist	48	13	23
recg.	DIDLE	2408	10	

	CENTIFICATE OF	DEATH Reg. Dist/ A67 35		
×.	1. PLACE OF DEATH: 2. USG	UAL RESIDENCE (HOME) OF DECEASED:		
legibly	50 COUNTY MORISONERS MARYLAND STA	ATE Maryland COUNTY Minlgomery		
and le		TY(If outside corporate limits, write RURAL and give pourest town)		
clearly	HOSPITAL OR INSTITUTION OR TRADE ADIENTIAL ADDRESS 7345 Holler Avenue ADI	DRESS 7305 Holly (While)		
death c	3. NAME OF (First) (Middle) (Last) DECEASED: (Type or Print) PERRY LESLIE KEEFE	4. DATE (Month) (Day) (Year) OF DEATH: My 4 1955		
of	MALE WHITE (Specify) 100 Thrown 16	5, 1880 74 yrs. Months Days Hours Min.		
the causes	10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OF INDUSTRY: Work done during most of working life, OF INDUSTRY: USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS OF INDUSTRY: OF INDUSTRY: OF INDUSTRY:	THPLACE (State of foreign country): 12. CITIZEN OF WHAT COUNTRY?		
		other's MAIDEN NAME:		
please write	15. WAR DECEASED EVER IN U.S. ARMER FORCEST (Yes, no. or unk.) (If Yes, give was or dates of service)	Le M. Leger, 7305 Holly We. J.P. Md.		
ea	18. MEDICAL CERTIFICATION	INTERVAL BETWEEN		
p		ONSET AND DEATH		
50	IMMEDIATE CAUSE (A) acute my	reardial tachere 15 min.		
ian	ANTECEDENT CAUSE (S)	1 -1 1 -1 1		
Physicians:	DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO	levotic Heart disease		
important.	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING			
ort	TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
up	19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?		
		YES NO NO		
especially	21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, factory, 21C OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., etc. INJ	C. WHERE DID (City or town) (County) (State)		
is est	OF HAJOR!	HOW DID INJURY OCCUR?		
	22. I hereby certify that I attended the deceased from tele, 1955, to april, 1955, that I last saw the deceased			
ect age	anve on	M, from the causes and on the date stated above.		
correct	Russell B. Unold M.D. S.	The Same, and 4 May 1955		
00	23 BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OF CONTROL REMOVAL (SPECIFY) May 6 1955	CREMATORY LOCATION (City, town, or county) (State)		
		FUNERAL DIRECTOR ADDRESS OF		

DECEDVED

BUREAU V. S.

M

I

483 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04814 Reg. Dist.

				. /
MEDICAL	EXAMINER'S	CERTIFICATE	OF DEATH	No. 2/6

county Montgomery MARYLAND	STATE Maryland county Montgomery		
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Kensington (in this place)	CITY (If outside corporate limits write RURAL and OR Kensington	give nearest town)	
HOSPITAL OR INSTITUTION OR 4101 Knowles Ave.	STREET ADDRESS 4101 Knowless Avecation)	/	
3. NAME OF (First) (Middle) DECEASED: (Type or Print) HERBERT NEWTON KEENE	(Last) 4. DATE (Month) (Day OF DEATH May 19,	(Year) 19 5 5	
5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): arried Sept	E OF BIRTH: 9. AGE last birthday: IF UNDER 1 Y		
10a. USUAL OCCUPATION (Give kind of work life, even if retired) Ret. Architect Self Emp.		CITIZEN OF WILAT COUNTRY?	
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:		
Herbert N. Keene, Sr.	Laura Gibson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES ? (Yes, no, or unk.) (If Yes, give war or dates of service) None	17. INFORMANT & ADDRESS: 10414 Parkwo	od Dr. Ington, Md.	
	CAL CERTIFICATION		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:	Value of the second	ONSET AND DEATH	
Antecedent cause(s) Diseases or conditions, if any, (b)		death	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes No	
21a. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING OF Street, office bldg., etc. CAUSE OF DEATH.	С.,	(State)	
21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED While at Not while INJURY M. work	21f. HOW DID INJURY OCCUR?		
REMOYAL (Specify) (: /	ident [], Suicide [], Homicide [], Undeter CIHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. RY OR CREMATORY LOCATION (Gity, town, or con-	mined cause DATE SIGNED 5-19.55	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REG. 121155 73	24 FINERAL PARECTOR	ADDRESS sda, Md.	

RECEIVED

2261 PS YAM

BUREAU V. S.

CERTIFICATE OF

4762

REMOVAL (SPECIFY)

DATE REC'D BY LOCAL

REGISTRA

PLEA

vi

The

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. No. (Day) (Year) IF UNDER 24 HRS. Months Days Hours 12. CITIZEN OF WHAT COUNTRY? 5.a INTERVAL BETWEEN ONSET AND DEATH

20. AUTOPSY?

YES

(County)

NO L

(State)

...., 19.55, that I last saw the deceased from the causes and on the date stated above.

DATE SIGNED

NAME OF CEMETERY LOCATION (City, town, or county) CREMATORY

FUNERAL DIRECTOR ADDRESS

The second of th

230: IS YAM

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 ()4816

4763

CERTIFICATE OF DEATH

Reg. Dist. No. 273

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:
COUNTY MONTGOMERY MARYLAND	STATE M.D COUNTY BALTIMORE
CITY (If outside corporate limits, write RURAL LENGTH OF STAY	CITY(If outside corporate limits, write RURAL and give nearest town)
OR and give nearest town) (in this place)	TOWN BALTIMORF MD 31/0/1
1 TOWN TAKOMA PARK 1 YR	PILL TIMORE TIP. SVOING
HOSPITAL OR AND INSTITUTION OR 7211 MADE ALL	STREET (If rural give location)
STREET ADDRESS /3/1- MAPLE AVE	3/05 OWANDA AVE V
	(Last) 4. DATE (Month) (Day) (Year)
(Type or Print) FANNIE LEAH KOMI	INETSKY OF DEATH: MAY 21 1955
5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE RACE: WIDOWED, DIVORCED,	OF BIRTH: 9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS.
F RACE: WIDOWED, DIVORCED, FEB	10, 1883 72 yrs. Months Days Hours Min.
IOA. USUAL OCCUPATION (Give kind of 108. KIND OF BUSINESS	11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT
work done during most of working life, even if retired):	PUSCIA SOUNTRY?
	(V35/A
13. FATHER'S NAME: BUPOWSKY	14. MOTHER'S MAIDEN NAME:
HYMAN TOM NETS!	MANNIE
15. WAR DECEASED EVER IN U.S. ARMED FORCEST 16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
(Yes, no, or unk.) (If Yes, give war or dates of service)	CLARA SCHWARTZ 131 MATERIA
18. MEDICAL CERTIFICATE	ION INTERVAL BETWEEN
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	ONSET AND DEATH
442 X	day's
IMMEDIATE CAUSE (A) Julmoni	ory earna 10 ment,
DUE TO	10.
ANTECEDENT CAUSE (S)	on the chrose Theraway some de 1715.
GIVING RISE TO THE ABOVE CAUSE	our ve and various various of 1 190
STATING UNDERLYING CAUSE LAST.	
(c)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING	
TO THE DEATH BUT NOT RELATED TO THE	
DISEASE OR CONDITION CAUSING DEATH	
194. DATE OF OPERATION: 198. MAJOR FINDINGS OF OPERATION	20. AUTOFST1
	YES NO
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fact	tory, 21c. WHERE DID (City or town) (County) (State)
OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg.,	etc. INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED) 21F. HOW DID INJURY OCCUR?
OF INJURY While Not while	ZIF. HOW DID INJURY OCCURY
M. at work at work	
22. I hereby certify that I attended the deceased from aug.	, 1934, to May 21 , 1955, that I last saw the deceased
	00/1050
alive on	M, from the causes and on the date stated above.
SIGNATURE .	ADDRESS MA STALL DATE SIGNED
semon C. Weiner M.	. D. 100 Houghellow NW May 4, 174
ES. BOTTINE, OTTENHENDER, CONTRACTOR	ERY OR CREMATORY LOCATION (City, town, or county) / (State)
REMOVAL (SPECIFY) 5-22-1955 Mt. COR	MEL BOLTO. UMD
DATE REC'D BY LOCAL REGISTRAD SIGNATURE	24. FUNERAL DIRECTOR ADDRESS

2361 PS YAM

BECEINED

DATE REC'D BY LOCAL

REGISTRAR



2. USUAL RESIDENCE (HOME) OF DECEASED COUNTY Montgomery CITY(If outside corporate limits, write RURAL and give nearest town) (If rural give location) DATE (Month) (Year) DEATH: 9. AGE iast birthday IF UNDER ! YEAR Hours 11. BIRTHPLACE (State or foreign country): |12. CITIZEN OF WHAT COUNTRY? Carolina W.S.A. 14. MOTHER'S MAIDEN NAME 4912 Red ford R thavine Krahnke Green Acres Md 20. AUTOPSYT large & Small witesting 2 fc. WHERE DID (City or town) (County) (State) 21F. HOW DID INJURY OCCUR? , 1945, to May 14, 19 17, that I last saw the deceased DATE SIGNED (State)

SOEL OI YAM

BECEINED

5103 Wisconsin Ave., N.W. Washington, D.C.

2361 ES YAM

BECEINED

the particular transmission (con test of)

18

	e l	MARYLAND STATE DEPARTMENT	T OF HEALTH—BALTIMORE, 18 04819
X	7. The	4835 CERTIFICATE	E OF DEATH Reg. Dist. No. 217
. 1	efully ibly.	1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:
	F4 0.0	COUNTY Montgomery MARYLAND	STATE Maryland COUNTY Montgomery
	ion ca	CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Olney LENGTH OF STAY (in this place) 12hrs. 40 min	CITY(If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring. 56
M	information clearly and	HOSPITAL OR The Montgomery County STREET ADDRESS General Hospital, Inc.	STREET (If rural give location) ADDRESS R#2 Peach Orchard Road
	ofath	DECEASED	(Last) 4. DATE (Month) (Day) (Year) OF DEATH: May 8 1955
	G 5		OF BIRTH: 9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS.
	-	male white (Specify):married Augus	st 3/1873 81 yrs. Months Days Hours Min.
Ö	causes	work done during most of working life, even if retired) painter 108. KIND OF BUSINESS OR INDUSTRY: Own business	11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT COUNTRY? Maryland U.S.A.
BINDIN	pply the	13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
313	Su	Joseph Leizear	Sarah Catherine Colbert

17. INFORMANT & ADDRESS: 15. WAS DECEASED EVER IN U.S. ARMED FORCEST 16. SOCIAL SECURITY NO. (Yes, no, or unk.) (If Yes, give war or dates Hospital Records of service) 18. MEDICAL CERTIFICATION INTERVAL BETWEEN DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH ONSET AND DEATH IMMEDIATE CAUSE DUE TO ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

PLAINLY, PIPE OR TYPE

MARGIN RESERVED FOR BIND

WI INK.

please

Physicians

important.

especially

age

correct

PLEASE

UNFADING

WITH

22. I hereby certify that I attended the deceased from 5 alive on J. SIGNATURE

OF INJURY

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

19A. DATE OF OPERATION:

21A. ACCIDENT WAS UNDERLYING

(IF EITHER, NOTIFY MEDICAL EXAMINER)

OR CONTRIBUTING CAUSE OF DEATH

21D. TIME (Month) (Day) (Year) (Hour)

DATE THEREOF

198. MAJOR FINDINGS OF OPERATION

at work

21B. PLACE (Home, farm, factory,

OF INJURY street, office bldg., etc.

While Not while

at work

NAME OF CEMETERY OR CREMATORY Union Cemetery

M. D.

ADDRESS

21c. WHERE DID (City or town)

21F. HOW DID INJURY OCCUR?

INJURY OCCUR?

J Jand that death occurred at 3, 50 9, M, from the causes and on the date stated above.

. 1951, to

LOCATION (City, town or county)

(County)

1955, that I last saw the deceased

DATE SIGNED

(State)

20. AUTOPSY?

(State)

Burtonsville, Maryland

DATE REC'D BY LOCAL

8434 Ga.

-10 - 53A15

S361 71 YAM

BECEINED

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

I. PLACE OF DEATH:		2. USUAL RESID	ENCE (HOME) OF DECE	SED:
COUNTY Montgomery	MARYLAND	STATE Mar	yland COUNTY	Montgomery
CITY (If outside corporate limits	write RURAL LENGTH OF	STAY CITY(If outside	corporate limits, write RURA	L and give nearest tow
56 TOWN and give nearest town) Silver Sprir	in this pl		ver Spring	56
HOSPITAL OR		STREET	(If rurai give locat	ion)
STREET ADDRESS 8606 Ce	dar Street	ADDRESS 86	06 Cedar Street	
3. NAME OF (First) DECEASED: ATLACE	(Middle)	(Last)	4. DATE (Month)	(Day) (Year)
(Type or Print)	Mary	Leonard	DEATH: May	21 19 55
RACE:	WIDOWED, DIVORCED.	/11/70	9. AGE last birthday IF UNDER Months	the state of the s
OA. USUAL OCCUPATION (Give kind	of 108 KIND OF BUSIN	ESS 11. BIRTHPLACE	(State or foreign country):	12. CITIZEN OF WH
work done during most of working even if retired!: Housewife	Own home		nada	convark.
3. FATHER'S NAME:		14. MOTHER'S M	IAIDEN NAME:	
William B. Boler		Ellen B	. Grogan	
WAS DECEASED EVER IN U.S. ARMED				0 2 01 1
Yes, no, or unk.) (If Yes, kive war o	none	Mrs.Margar	et M. Tuhy, 8606	
	18. MEDICAL CERT		Silver	Spring, Md.
I DISEASES OR CONDITIONS DIE	RECTLY LEADING TO DEATH			ONSET AND DEA
1443 X IMMEDIATE CAUSE	(A) Car	Diac Deco	mpansation	6-8 gr
ANTECEDENT CAUSE (5)	DUE TO			
DISEASES OR CONDITIONS, IF AN	IY, (B) Hy	berlenown		7.
GIVING RISE TO THE ABOVE CAUSTATING UNDERLYING CAUSE LA	SE DUE TO			
	(c) acts	moselevan	00	~
TO THE DEATH BUT NOT RELA		1.1		9
DISEASE OR CONDITION CAUS	MAJOR FINDINGS OF OPE			
O TOPERATION: 198.	MAJOR FINDINGS OF OPE	RATION		YES NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DE	ATH OF INJURY street, offic	m, factory. 21c. WHERE bldg., etc. INJURY OCCU	DID (City or town) (C	ounty) (State)
(IF EITHER, NOTIFY MEDICAL EXAMINER 21D. TIME (Month) (Day) (Year)		URRED 21F HOW DID	INJURY OCCUR?	
OF INJURY	M. at work at wor	iile 🦳	INDUNI COCCIN	
			14-4-1055	
22. I hereby certify that I atte	The same of the sa			
alive on	, and that death occurr	red at M, from t		te stated above.
Willen D.	and	M. D. Selver	Abrune .	5/21/55
23. BURIAL, CREMATION, DATE	THEREOF NAME OF		Y LOCATION (City, town	
Trans. & Burial 5/2	24/55 St.Fran	cis Cemetery	Oakland, Mass	achusetts
DATE REC'D BY LOCAL REGISTRAR	STRAR'S SIGNATURE	24. FUNERAL	DIRECTOR 8432	Ga. Ave.

THE REPORT OF THE PERSON OF THE PROPERTY OF THE PERSON OF

DECEIVED V. S. BUREAU V. S.

	The	4837 MARYLAND STATE DEPARTMENT tem 18 Film G182 5-27-55 amCERTIFICATE		04821
1	÷		OF DEATH Reg. Dist.	No.
X	carefull legibly.	1. PLACE OF DEATH:	-TT	0
	are	COUNTY THOUGH O MENY MARYLAND	3.7	orgonevy
		OR and give nearest town.	CITY(If outside corporate limits, write RURAL s	nd give nearest town)
	tion	X TOWN Dettesda	TOWN Dilversprings,	56
W.	information clearly and	HOSPITAL OR INSTITUTION OR TINSTITUTION OR TIN	STREET ADDRESS 803	,,,
1	ofic	14 Sucuration	(ast) . 4. DATE (Month)	Day) (Year)
	f ii	3. NAME OF (First) (Middle)	V OF	1 100
	em of i	(Type or Print) Wiss Illinia T. LOCSCI		0 1953
	item of de	5. SEX: 6. COLOR OR 7. SINGLE MARRIED, 8. DATE WIDOWED, DIVORCED,		ays Hours Min.
		(Specify): July K	1 1900 54 yrs.	
	causes	10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS	BIRTHPLACE (State or foreign country): 12.	
C	eva	work done during most of working life. OR INDUSTRY: even if retired) Cafeteria Worker, Jr. High School	Maryland	COUNTRYS
Z	200	13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	7/13
BINDIN	Supply te the c	Tank boesch Ke	Wilhelmina Booker	
B	K. Su write	15. WAS DECEASED EVER IN U.S. ARMED FORCEST 16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS 625 Dennis	on St.
OR		(Yes, no, or unk.) (If Yes, give war or dates of service) 217-32-2458		Ltimore, Md.
<u>E</u>	G IN	18. MEDICAL CERTIFICATION		INTERVAL BETWEEN
8	NG	I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		ONSET AND DEATH
\geq	DIN	223X -P 1:1		26
8		IMMEDIATE CAUSE (A) Lightrat	my tarlure	& cironso
RESERVED	UNFA	ANTECEDENT CAUSE (S)		201
2	Usic	DISEASES OR CONDITIONS, IF ANY. (B)	Leen Yours	2 days
Z	ITH Phys	GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST.	oclieved to be a Meningioma)	
3		(C) Framoton	in Lor Brain Turner	4 days
ARGIN	AINLY, Wimportant.	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING	10	
Z	Y,	TO THE DEATH BUT NOT RELATED TO THE	in Treneus obstruction	2 tiones
	N od	DISEASE OR CONDITION CAUSING DEATH.	0.00	1 22 11111111
	AINLY	19A. DATE OF OPERATION: 19B. MAJOR PHADINGS OF OPERATION		YES NO
	. 7	Tilay 6, 195 S.		
1	Eis E	21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, factor of CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., of the contribution of	ory, 21c. WHERE DID (City or town) (Countetc. INJURY OCCUR?	(State)
	/RIT	210 TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
-	≥ •	OF INJURY While at work at work		
	OR e is		10.52 . 10 10 00 551 1 7 1	11 1 1
	20	22. I hereby certify that I attended the deceased from J.2 4.		
23	TYPE rect ag	alive on . 10 May, 19.55, and that death occurred at	1.17 AM, from the causes and on the date	stated above.
-	Y	SIGNATURE LO	ADDRESS DA	LE SIGNED 19 MA
7		Emes Externor M.		JA Mus 53
	SE		RY OR CREMATORY LOCATION (City, town, of	county) (State)
12	EASE	REMOVAL (SPECIFY) 5/13/55 Rock Creek Co	emetery Washington, D.	C.
4	PLF	DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE		ADDRESS AVE.
S	Н	REGISTRAR 5 1715 1 Page My Change to and		
-		The state of the free the state of the state	Warner to Tumphrey, Silver	opring, Md.



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BUREAU V. S.

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BECEINED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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D!-4	BT -				

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The

MARGIN RESERVED FOR BINDING

VS. A15

Item 14 FilmGlab Till CATE OF DEATH

000	Dist.	No	

2050 CERTIFICATE	CF DEATH Reg. Dist. No.
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:
COUNTY Montgomery MARYLAND	STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL) LENGTH OF STAY	CITY(If outside corporate limits, write RURAL and give nearest town
OR and give nearest town) (in this place)	OR TOWN Pothogen
X TOWN Bethesda Rural 2 Days	Decriesus
HOSPITAL OR INSTITUTION OR 5/STREET ADDRESS U. S. Naval Hospital	ADDRESS 2200 III coonsin Arrange
J. O. D. Mavar Mosproar	(Last) 4. DATE (Month) (Day) (Year)
S. NAME OF (First) (Middle) (DECEASED: (Type or Print) Victor Wayne MARSH	(Last) 4. DATE (Month) (Day) (Year) OF DEATH: May 2 1955
	OF BIRTH: 9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS.
RACE: WIDOWED, DIVORCED,	Months Days Hours Min.
Male Caucasian (Specify): Single 11-	-30-54 yrs. 5 2
OA. USUAL OCCUPATION (Give kind of work done during most of working life, OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHA
even if retired): Infant Not Applicable	Maryland US
3. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Walter J. MARSH	LINTHICUM, Suzanne
B. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
(Yes, no, or unk.) (If Yes, give war or dates of service)	Walter J. MARSH (Father) Same as above
18. MEDICAL CERTIFICAT	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	ONSET AND DEAT
4907 melinos	na , lobar , left lung 48hrs
IMMEDIATE CAUSE (A) DUE TO	
ANTECEDENT CAUSE (S)	
DISEASES OR CONDITIONS, IF ANY, (B)	
STATING UNDERLYING CAUSE LAST.	
(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING	
TO THE DEATH BUT NOT RELATED TO THE	
DISEASE OR CONDITION CAUSING DEATH.	
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION	20. 20101311
	YES NO
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fact OF CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg.,	tory, etc. INJURY OCCUR? (City or town) (County) (State)
(IF EITHER, NOTIFY MEDICAL EXAMINER) 21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED	2 1F. HOW DID INJURY OCCUR?
OF INJURY M. at work at work	
20 4	med 310 55 + 2 Warm 10 55 +1 - + T 1 - + + +1
22. I hereby certify that I attended the deceased from 30 A	the transition of the transition of the transition of the decease
1955 and that death occurred at	16:20M, from the causes and on the date stated above.
SCHATURE	ADDRESS DATE SIGNED
D. J. PASCOE LT, MC, USN	DUSNH, NNMC, Bethesda, Md.
23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETE	ERY OR CREMATORY LOCATION (City, town, or county) (State
Delicoviction of the second of	
	ational Cemetery Arlington, Virginia
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR MALLE STATELLE	24. FUNERAL DIRECTOR ADDRESS T. A. Pumphrey Funeral Home 7557 Wisconson Avenue, Bethesda, Marylan



2391 6 YAN

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE 1. PLACE OF DEATH: 2. USUAL RESIDENCE (HOME) OF DECEASED: COUNTY MARYLAND STATE COUNTY CITY (If outside corporate limits, write RURAL LENGTH OF STAY CITY (If outside corporate limits write RURAL and give nearest town) OR and give nearest town) (in this place) TOWN HOSPITAL OR STREET (If rural, give location) ADDRESS INSTITUTION OR STREET ADDRESS (First) (Middie 3. NAME OF (Last) 4. DATE (Month) DECEASED: OF (Type or Print) DEATH 6. COLOR OR 7. SINGLE. MARRIED 8. DATE BIRTII: 9. AGE last birthday: AF UNDER 1 YEAR | IF UNDER 24 HRS WIDOWED, DIVORCED, RACE: Months (Specify): Suite 10b. KIND OF BUSINESS OR 10a. USUAL OCCUPATION (Give kind of /11. BIRTHPLACE (State or foreign country): work done during most of work life, INDUSTRY: even if retired): 14. MOTHER'S MAIDEN NAME: 13. FATHER'S NAME: WAS DECEASED EVER IN U.S. ARMED FORCES ? 16. SOCIAL SECURITY NO.: 17. INFORMANT & ADDRESS: (Yes, no, or unk.) | (If Yes, give war or dates of service) 18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 812X Immediate cause Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 19a. DATE OF OPERATION: | 19b, MAJOR FINDING OF OPERATION: 21a. EXTERNAL CAUSE WAS (County) 21b. PLACE (Home, farm, factory, 21c. (City or town) PRIMARY or CONTRIBUTING CAUSE OF DEATH. street, office bldg., etc., INJURY Fustano demisvell

21f. HOW DID INJURY OCCUR 21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED While at Not while INJURY work [at work broknery in 22. I hereby certify that I took charge of the remains described above, held an Autopsy 27, Anspection 1 , Inquiry 1. find that death resulted from: Natural causes [, Accident [, Suicide [, Homicide [, Undetermined cause []. CHIEF MEDICAL EXAMINER SIGNATURE DATE SIGNED DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. M. D.

23. BURIAL, CREMATION DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county). (State) REMOVAL (Specify) REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

DATE REC'D BY LOCAL

ancesil

Reg. Dist.

(Year)

19 5

12, CITIZEN OF WHAT

INTERVAL BETWEEN

ONSET AND DEATH

20. AUTOPSY? Yes No 🗌

(State)

COUNTRY?

(Day)

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Supply every item of information carefully. The

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK.

CERTIFICATE OF DEATH

Reg. Dist. No. 2/6

1010 CIII	TITI TOTAL	d OI DEAR	TAL Neg.	Dist. No. F. H. A. H.
1. PLACE OF DEATH:		2. USUAL RESID	ENCE (HOME) OF DECE	EASED:
COUNTY Montgomery	MARYLAND	STATE Penns	sylvaniacounty	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Bethesda	(in this place)	CITY(If outside OR TOWN Ship		RAL and give nearest town)
V Decileada	23 days	STREET	(If rural give loc	ation)
HOSPITAL OR The Clinical Cent STREET ADDRESS Natl. Institutes		ADDRESS R.D.		1
3. NAME OF (First) . (Mid	idle)	(Last)	4. DATE (Month)	(Day) (Year)
DECEASED: (Type or Print) Ann	A. McCo	ormick	of DEATH: May	20 19 55
5. SEX: 6. COLOR OR 7. SINGLE, MARR WIDOWED, DIV (Specify): C.1.	ORCED, 8. DATE	OF BIRTH:	9. AGE last birthday Mont	DER 1 YEAR IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of 10B. KINI		ine 1950	Ap P	12. CITIZEN OF WHAT
work done during most of working life, even if retired): Child	INDUSTRY:		ylvania	COUNTRY? U.S.A.
13. FATHER'S NAME:		14. MOTHER'S M	AIDEN NAME:	
John P. McCormick		Marga	ret Kane	
	CIAL SECURITY NO.	17. INFORMANT		
(Yes, no nor unk.) (If Yes, give war or dates of service)	None	The medical:	record, The Clir	nical Center
1 DISEASES OR CONDITIONS DIRECTLY LEADING 15 HIMMEDIATE CAUSE (A) ANTECEDENT CAUSE (S)	Chronic he	eart failure		ONSET AND DEATH
DISEASES OR CONDITIONS, IF ANY. (B)		l cyanotic he	art disease	
STATING UNDERLYING CAUSE LAST. (C)	Pulmonary foramen or		is and patent	
II OTHER SIGNIFICANT CONDITIONS CONTRIB TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	uting	Lacat	mo	
194. DATE OF OPERATION: 198. MAJOR FINDI	NGS OF OPERATIO	N/		20. AUTOPSY?
May 20, 1955 3 Pulmonary s	tenosis			YES NO
21A. ACCIDENT WAS UNDERLYING OF ON CONTRIBUTING CAUSE OF DEATH OF INJUSTICAL EXAMINER)	CE (Home, farm, fac RY street, office bldg.,	tory, 21c. WHERE INJURY OCCU		(County) (State)
		21F. HOW DID	INJURY OCCUR?	
22. I hereby certify that I attended the dece alive on May 20, 1955, and that SIGNATURE 23. BURIAL CREMATION, DATE THEREOF REMOVAL (SPECIFY)	death occurred at	11:00 M, from t	he causes and on the causes and on the causes and on the causes are trutes of Health	date stated above. DATE SIGNED 5/20/55
Burial-Transit 5-20-55	VIIII	1 A AMERAL	DIRECTOR .	ADDRESS.

DECEDVED MAY 26 1955

BUREAU V. S.

VS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.	6	
rece. Dioce		

MEDICAL EXAMINER'S CER	RTIFICATE OF DEATH	No. 4 23
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY MINTEROMORY MARYLAND	STATE md COUNTY Month	
CITY (If outside corporate limits, write RURAL OR and give nearest (town) TOWN Takemar Ruck LENGTH OF STAY	CITY (If outside corporate limits write RURAL and OR TOWN Takena Carl	give nearest town)
HOSPITAL OR INSTITUTION OR Wash, San, + Hosp.	STREET (If rural, give location) ADDRESS 73/0 Willow aux	/
3. NAME OF (First) (Middle) DECEASED: (Type or Print) Charles Leonard Mc((Last) 4. DATE (Month) (Day) OF DEATH May 3/	19475
M RACE: WIDOWED, DIVORCED, (Specify):		Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	Takoma Park , Md.	CITIZEN OF WILAT
13. FATHER'S NAME: Mr Charles J Mc Cornick	14. MOTHER'S MAIDEN NAME: Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	17. INFORMANT & ADDRESS:	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 49/ Immediate cause (a)	preum oria	INTERVAL BETWEEN ONSET AND DEATH
Antecedent cause(s) Diseases or conditions, if any, (b) giving rise to the above cause of the above	/	
IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes No
21a. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING OF Street, office bldg., et CAUSE OF DEATH.	ic.,	(State)
21d. Time (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED While at Not while INJURY M. work at work		
22. I hereby certify that I took charge of the remains described that death resulted from: Natural causes of, Account Thank I Broschart	cident [], Suicide [], Homicide [], Undetcr CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM.	mined cause DATE SIGNED
23. BURIAL CREMATION, DATE THEREOF NAME OF CEMETE REMOVAL (Specific G-2-55 Hellers)	Buril Park Cumberland	Maryland, DDRESS

OBAMBORAL PROPERTY.

BUREAU V. S.

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VS.

0)	MARYLAND STATE DEPARTMENT	of health—baltimore, 18 04827
. The	4841 CERTIFICATE	OF DEATH Reg. Dist. No. 2/6
carefully.	1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:
carefull legibly.	county, Montgomery MARYLAND	STATE Maryland county Prince George
	CITY (If outside corporate limits, write RURAL LENGTH OF STAY (in this place)	CITY(If outside corporate limits, write RURAL and give nearest town) OR TOWN Hyattsville /6/5-2
ation 7 and	Town Bethesda 7 days HOSPITAL OR The Clinical Center	CTREET (If were) give location)
item of information of death clearly and	50 INSTITUTION OR National Institutes of Health	ADDRESS 5902 36th Ave.
inf h cl	DECEMBED.	Last) 4. DATE (Month) (Day) (Year)
m of i	(Type or Print) Arthur Leo MCW11113	V
	5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, RACE: WIDOWED, DIVORCED. (Specify): Single 5/26/4	7 yrs, Months Days Hours Min.
causes	IOA. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): (%) 104 0 0 0 100USTRY:	District of Columbia 12. CITIZEN OF WHAT COUNTRY? U.S.A.
~ 0	even if retired): Child	14. MOTHER'S MAIDEN NAME:
Supply te the c	Ernest McWilliamson	Mary Goode
. S.	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
INK.	(Yes, no, or unk.) (If Yes, give war or dates of service) none	The medical record, The Clinical Center
UNFADING INK. Supply sicians: please write the	18. MEDICAL CERTIFICATION DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	ON INTERVAL BETWEEN ONSET AND DEATH
ADI	33/X IMMEDIATE CAUSE (A) Cerebral he	emorrhage, base of brain
NF	IMMEDIATE CAUSE (A) DUE TO	
F.	DISEASES OR CONDITIONS, IF ANY. (B) Pulmonary	edema
-	GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST.	
AINLY, Wimportant.	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING	
LY	DISEASE OR CONDITION CAUSING BEATH.	ism and liver necrosis
4	19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES TO NO
- des	21A. ACCIDENT WAS UNDERLYING CR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., (IF EITHER, NOTIFY MEDICAL EXAMINER)	ory, 21c. WHERE DID (City or town) (County) (State)
WR]	21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while at work at work	21F. HOW DID INJURY OCCUR?
OR e is	22. I hereby certify that I attended the deceased from May	2, 1955, to May 9, 1955, that I last saw the deceased
(五 g	alive on May 9 1955, and that death occurred at	8:30a M, from the causes and on the date stated above. ADDRESS DATE SIGNED
	SIGNATURE M. Darrott M.	The Clinical Center 5/9/55
PLEASE	23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETE	
LE	DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	242 FUNERAL DIRECTOR 308 ADDRESS ONE
1	REGISTRAR 5/9/5 to 10. L	Tel Flores House Manh 1:0.

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BUREAU V. S.

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PLEASE TYPE

Supply every item of information carefully. The

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4766 CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

RE, 18 04828 Reg. Dist. No. 223....

ly.	1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:
legibly	COUNTY Montgomery MARYLAND	STATE Manufand Source Mandana
leg	CITY (If outside corporate limits vrite RURAL) LENGTH OF STAY	STATE Mary and COUNTY Montgomery CITY(If outside Orporate limits, write RURAL and live nearest town)
and	TOWN (in this place)	OR TOWN TO 1
	HOSPITAL OF COLOR	STREET (If rural give location)
arl	MASTITUTION OR Washington Sanitarium	ADDRESS
clearly	/V Hesorial	808 Houston Que.
	3. NAME OF (First) (Middle)	Last) 4. DATE (Month) (Day) (Year)
death	(Type or Print) Trench Sterling Head	10WS DEATH: 5 - 22 1955
	Dien Humanien miliatore	OF BIRTH: 9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS.
of	male white (Specify) married 9-24	+-89 65 yrs. Months Days Hours Min.
causes	TOA. USUAL OCCUPATION TOISE KIND OF BUSINESS	11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT
can	even if retired):	Country?
the	13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
	Slacker Meadous	Viscinia Maufield
write	15. WAS DECEASED EVEN IN U.S. ARMED FORCEST 16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
	(Yes, no, or unk.) (If Yes, give war or dates of service)	Il soilal Part
ase	18. MEDICAL CERTIFICAT	Hospital Kecord
plea	I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN
	0 + -	A A A A
ns	260 XMMEDIATE CAUSE (A) Leux-Ou	low crox any shamboris 9 days
Physicians	ANTECEDENT CAUSE (8)	
ysi	DISEASES OR CONDITIONS, IF ANY, (B) GOLOGO	liged gething -
Ph	STATING UNDERLYING CAUSE LAST. DUE TO	1 11-4
ند	(c) please	y wellies -
important.	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE	0 - 2004
OC	DISEASE OR CONDITION CAUSING DEATH. Chilliant	class Offillians of lower oftentie
m	19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES NO
pecially	21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fact	ory. 21c. WHERE DID (City or town) (County) (State)
eci	OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., (IF EITHER, NOTIFY MEDICAL EXAMINER)	etc. INJURY OCCUR?
esp	21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while	21F. HOW DID INJURY OCCUR?
S	OF INJURY M. at work at work	
9	22. I hereby certify that I attended the deceased from way	13. 1955 tohioy 22. 195 that I last saw the deceased
28	alive on May 72, 1955, and that death occurred at	
ct	SIGNATURE 1930, and that death occurred at	ADDRESS DATE SIGNED
correct	Sud ver Toventile In. R	o Selver thing and may 22 1955
00	23 BURIAL CREMATION DATE THEREOF / NAME OF CEMETE	
	BUDID 5 1 5 5 4T Linear	In term Prince Glotor Indi
	DATE REC'D BY LOCAL DESISTRAB'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
	REGISTRAR 2 1/1965 XITTUININ VIOLA	W/ X X/ 11110 000 673 2

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(Day)

Days

(Year)

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INTERVAL BETWEEN

ONSET AND DEATH

20, AUTOPSY?

(State)

(State)

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DATE SIGNED

(County)

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

. The	4842 CERTIFICATE OF DEATH Reg. Dist.	No. 216
information carefully clearly and legibly.	CITY (If outside corporate limits, write RURAL OR and give nearest town) HOSPITAL OR INSTITUTION OR STREET ADDRESS (If rural give location)	gomen
every item of informaticanses of death clearly	DECEASED: (Type or Print) 5. SEX 6. COLOR OR 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) 10A. USUAL OCCUPATION (Give kind of 10B. KIND, OF BUSINESS work done during most of working life, OR INDUSTRY: DEATH: OF DEATH:	ays Hours Min.
INK. Supply tse write the c	13. FATHER'S NAME: 14. MOTHER'S MAIDEN NAME: 15. WAS DECEASED EVER IN U.S. ARMED FORCES! (Yes, no or unk.) (If Yes, give war or dates of service) 18. MEDICAL CERTIFICATION	INTERVAL BETWEEN
TH UNFADING Physicians: plea	I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 332 IMMEDIATE CAUSE ANTECEDENT CAUSE (5) DISEASES OR CONDITIONS, IF ANY. GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) DUE TO	37 News
AINLY, WI important.	(C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
WRITE s especial	21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, factory. OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., etc. INJURY OCCUR? 21D. TIME (Month) (Day) (Year) (Hour) While Work at work at work at work 1 at wor	y) (State)
ASE TYPE OR correct age is	22. I hereby certify that I attended the deceased from alive on Signature alive on Signature And that death occurred at Andress Address Addres	stated above.
PLEA	DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR 6/1/55 Beasie M. Hompson W. W. Chambes Co. wash.	ADDRESSN. W

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y. Th	Item 7, Film G181, 5/11/55 CERTIFICATE	COF DEATH Reg. Dist. No. 2/6
oly.	1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:
careful	COUNTY THOMESOMELY MARYLAND	STATE Marylandunty Montgomery
ce 1 Je	CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give parest total) (in this place)	CITY(If outside corporate imms, write RURAL and give neares town)
tion	X TOWN Defferdal	TOWN TIEN ECLO
of information carefully ath clearly and legibly.	HOSPITAL OR INSTITUTION OR SUBJECT ADDRESS	STREET ADDRESS ADDRESS ADDRESS
infe	3. NAME OF (First) (Middie)	Last) 4. DATE (Month) (Day) (Year)
	(Type or Print) IN vs. Bla R Tiloney	OF DEATH: May 3, 1955
ite	5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE WIDOWED, DIVORCED, (Specify): Married	9. AGE iast birthday IF UNDER 1 YEAR HOURS Min.
causes	IOA. USUAL OCCUPATION (Give kind of work done during most of working me, even if retired); OR INDUSTRY:	1) BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT
	13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Supply te the c	Klein	UNXWOOWN
. "	15. WAS DECEASED EVER IN U.S. ARMED FORCEST 16. SOCIAL SECURITY NO.	17. ANFORMANT & ADDRESS:
INK se w	(Yes, no, or unk.) (If Yes, give war or dates of service)	Cedrie 1, Money
	18. MEDICAL CERTIFICATI	ON INTERVAL BETWEEN
ADINGs: plea	I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	ONSET AND DEATH
FAD ns:	331 IMMEDIATE CAUSE (A) Christia	ascales seculent 4 days
UNF	ANTECEDENT CAUSE (8) DUE TO	to .
WITH UNFAI	DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO	www
-	(c)	
~ 65	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE	
AINLY, Wimportant.	DISEASE OR CONDITION CAUSING DEATH.	
PLAINLY lly import	19a. DATE OF OPERATION: 19a. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
PL. ly		YES NO NO
VRITE PL especially	21a. ACCIDENT WAS UNDERLYING ☐ 21a. PLACE (Home, farm, facto OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	ory. 21c. WHERE DID (City or town) (County) (State) etc. INJURY OCCUR?
>	ZID. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while at work at work at work	21F. HOW DID INJURY OCCUR?
OR e is		1055 to 5/2 10 65 that I look somethy decreed
	22. I hereby certify/that I attended the deceased from 750	, 1955, to 5/3, 1955, that I last saw the deceased
۵.	alive on , 1933, and that death occurred at	AM, from the causes and on the date stated above.
SE TYI	// +	0.6306 Wiscourin are a ch. ml 5/3/55
02	23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETE	
LEA	REMOVAL (SPECIFY) 5/6/55 Washington	m Vatural Surtland Md.
PL	DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
	REGISTRAR 5/6/55 Beasie M. Thomkson	W.W. Chambraco So72: M-St NW.
		Wanto-C-

1/84 8010 100 Lasser Civile

M	The correct age
- 1	The
•	of information carefully.
SNICINIA AC	every item of
20	evel

MARYLAND STATE DEPARTMENT OF HEALTH

Aヴァッ 2411 N. Charles Street, Baltimere

CERTIFICATE OF DEATH

Reg. Dist. No. 213...

04832

I. PLACE OF DEATH	on toomer	MARYLAND	2. USUAL RESIDENCE (H		OUNTY /
CITY (If outside co	rporate Amita, write RUR.	AL and LENGTH OF STAY	CITY (If outside corpora	te limits, write RURAL	and give nearest town)
OR give nearest	KOCK ///E	5 Mon	TOWN ROCK	ville	26
HOSPITAL OR INSTITUTION OF STREET ADDRESS	R SS		STREET ADDRESS /320	ARDEN	ves Ave 1
3. NAME OF	(First)	(Middle)	(Last)	4. DATE (Mon	th) (Day) (Year)
(Type or Print)	Cinna	Justine	moomey	DEATH May	20, 1955
FEMALE	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		9. AGE last birthday /1	funder i year If under 24 hrs. Months Days Hours Min.
done during most of w	TION (Give kind of work orking lift) even if retired)	INDUSTRY HOM &	BeRWICK	foreign country)	12. CITIEN OF WHAT
13. FATHER'S NAM	E		14. MOTHER'S MAIDEN	NAME	,
JIMO	N SITLE	R	EL1246.	eth De	Long
(Yes, no, or upkpown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	The MA MO	ADDRESS	
		18. MEDICAL CE	RTIFICATION		
I. DISEASES OR CO	NDITIONS DIRECTLY	LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATE
Immediate	cause (a)	Cardir - re	opinating Fa	ilune	301
Anteceden Diseases or e	t cause(s) conditions, if any, (b)	myound	lil Difans	Lin	6 mm
stating the u	nderlying cause last (c)	Coronany	artenosilis	osis	Indefinite
	CANT CONDITIONS ting to the death but not se or condition causing deat	n nahe			
19a. DATE OF OPE	RATION 196. MAJOR F	INDINGS OF OPERATION			20. AUTOPSY?
6/					Yes No D
21. ACCIDENT SUICIDE HOMICIDE	(Specify) PLACOF	CE (Home, farm, factory, street, office bidg., etc.) URY	(CITY OR T	OWN) (CO	UNTY) (STATE)
TIME (Month) OF INJURY	(Day) (Year) (Hour) m.	INJURY OCCURRED While at Not While Work At work	HOW DID INJURY OCC	URT	
22. I hereby certi	fy that I attended the	e deceased from 9/2	/, 1954, to 5/2	0/, 1955, that I	last saw the deceased
alive on S	720/1955 an	d that death occurred at	1:55 P m from the	rouges and an the d	ate stated shows
SIGNATURE	11100	(Degree or title)	ADDRESS	causes and on the t	DATE SIGNED
JA TE	Mun h for	mes mal	Kortrille	mel.	5/20/55
23 BURIAL CREM	ATION DATE THEREO	SS PINC GR	RY OR CREMATORY LO	DERWICK	PA. (State)
DATE REC'D BY I	OCAL REGISTRAR'S	Signature Traglars	W. W. Chame	,	ADDRESS 2 M S + N W
				007	

DECEDVED MAY 25 1955

BUREAU V. &

(Day)

Days

COUNTRY?

(Year)

1955

IF UNDER 24 HRS.

ONSET AND DEATH

20. AUTOPSY?

NO V

(State)

(State)

YES [

DATE SIGNED

or county)



	item
51	every
BINDIN	Supply
FOR	INK.
MARGIN RESERVED FOR BINDING	PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item
ARGIN	WITH
N. N.	PLAINLY,
	WRITE
	OR
10 - 53	TYPE
s. A15 — 10 - 53	EASE
ró	PL

VS.

MARYLAND	STATE	DEPARTMENT	OF	HEALTH—BALTIMO	RE,	18	048	834	
	CEL	RTIFICATE	OF	DEATH	Rom	Diet	No	21	>

1. PLACE OF DEATH:		2. USUAL RESIDE	ENCE (HOME) OF DECEASE	D;		
COUNTY Montgomery	STATE Md.	COUNTY Mont	zomery			
CITY (If outside corporate limits, write RURAL) OR and give nearest town)	LENGTH OF STAY	OP	corporate limits, write RURAL			
X TOWN Olney	2 days	TOWN Rura	al - Cedar Grove	Э Х		
HOSPITAL OR OR INSTITUTION OR		STREET ADDRESS R. F	F.D. #1 Germant	own /		
3. NAME OF (First) (Mic		Last)		Day) (Year)		
DECEASED: (Type or Print) Samuel Euge	ene Mul	linix	OF DEATH: 5/8/55	19		
5. SEX: 6. COLOR OR 7. SINGLE, MARR WIDOWED, DIV (Specify): mar	IED. 8. DATE	OF BIRTH: 9	9. AGE last birthday IF UNDER 1 40 yrs. Months 1	YEAR IF UNDER 24 HRS. Days Hours Min.		
OA. USUAL OCCUPATION (Give kind of work done during most of working life. OR	D OF BUSINESS INDUSTRY: 11 & Threship		State or foreign country): 12.	CITIZEN OF WHAT COUNTRY? U.S.A.		
3. FATHER'S NAME:	TT OC THE COULT	14. MOTHER'S MA		0.0.2.		
Samuel E. Mullinix		Elsie	Moxley .			
. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SO	CIAL SECURITY NO.	17. INFORMANT & ADDRESS:				
(Yes, no, or unk.) (If Yes, give war or dates of service)	5-26-9128	Hospit	al records			
18. MEDICAL CERTIFICATION						
I DISEASES OR CONDITIONS DIRECTLY LEADIN	NG TO DEATH			ONSET AND DEATH		
IMMEDIATE CAUSE (A)	Gastro-inte	stinal hemor	rhage	60 hours		
ANTECEDENT CAUSE (S)						
DISEASES OR CONDITIONS, IF ANY. (B) Metastatic melanoma of liver						
GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST.				-1		
(C)		alignant) re	tina left gye	2½-3 years		
OTHER SIGNIFICANT CONDITIONS CONTRIB TO THE DEATH BUT NOT RELATED TO THE	UTING					
DISEASE OR CONDITION CAUSING DEATH, 19a, DATE OF OPERATION: 19B, MAJOR FINDI						
O I I MADON TINON	NOS OF OFERATION			YES NO		
21A. ACCIDENT WAS UNDERLYING \(\) DR CONTRIBUTING \(\) CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	CE (Home, farm, fact RY street, office bldg.,	etc. INJURY OCCUP	OID (City or town) (Coun	ty) (State)		
21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED 21F. HOW DID INJURY OCCUR? While Not while at work at work						
22. I hereby certify that I attended the deceased from 4/10/, 1955, to 5/8, 1955, that I last saw the deceased						
alive on May 8						
Oiling I meader	und M.	D. Damascus	May May	8, 1955		
		- CHILLIAN - U.S.	LOCATION (City, town, o	r county) (State)		
REMOVAL (SPECIFY)	NAME OF CEMETE	RY OR CREMATORY				
	Salem	24. FUNERAL D	Gedar Grove	Md. ADDRESS		



VS. A15 - 10 - 53

10	MARYLAND	STATE	DEPARTMENT	OF	HEALTH—BALTIMORE,	18	0483
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S45 CERTIFICATE	\mathbf{OF}	DEATH
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Reg. Dist. No. 2/6

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:
county Montgomery MARYLAND	STATE Maryland county Montgomery
CITY (If outside corporate limits, write RURAL) LENGTH OF STAY	STATE Maryland COUNTY Montgomery CITY(If outside corporate limits, write RURAL and give nearest town)
OR and give nearest town) (in this place)	Town Bethesda
A De one Sua	STREET (If rural give location)
HOSPITAL OR INSTITUTION OR COOK S	ADDRESS
STREET ADDRESS 7108 Exfair Rd	7108 Exfair Rd
	(Last) 4. DATE (Month) (Day) (Year)
OECEASED: (Type or Print) Peter T. Mu:	rphy DEATH: 5 31 19 55
5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE	OF BIRTH: 9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS.
Male White Specify): Single April	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT COUNTRY?
even if retired): Retired U.S. Gov.	Ireland U.S.
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Terence Murphy	Ellen Traynor
15. WAS DECEASED EVER IN U.S. ARMED FORCES! 18. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS: Margaret Collins
(Yes, no, or unk.) (If Yes, give war or dates None	7108 Exfair Rd. Bethesda, Md.
18. MEDICAL CERTIFICAT	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	ONSET AND DEATH
420.0	1 - 1 - 11 1 D - 1 - 1
IMMEDIATE CAUSE (A) HRTERIO J	cleratic Heart Disease 6475
ANTECEDENT CAUSE (S)	
DISEASES OR CONDITIONS, IF ANY, (B)	
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	
(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE	
DISEASE OR CONDITION CAUSING DEATH.	
194. DATE OF OPERATION: 198. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	YES NO Z
21A ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fact	tory, 21c. WHERE DID (City or town) (County) (State)
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fact OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while	21F. HOW DID INJURY OCCUR?
OF INJURY M. at work at work	
	2 10 53 to MM 21 10 5 1 That I last now the decorate
22. I hereby certify that I attended the deceased from May	
alive on MA431, 1957, and that death occurred at	M, from the causes and on the date stated above.
SIGNATURE O	ADDRESS DATE SIGNED
	.D. Bethesda 8-31-55
23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETE REMOVAL (SPECIFY)	ERY OR CREMATORY LOCATION (City, town, or county) (State)
Burial 0-2-1955 Ft. Linco	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	Robert a Remphrey Bethesda, Md.
1/30 NOSALE MIL PROMICEDY	- Company of the comp

THE CELVED

BUREAU V. S.

ADING INK.

Supply every item of Information carefully. The

RESI	UNF
MARGIN	WITH
M	RE TYPE OR WRITE PLAINLY.
	WRITE
	OR
	TVPE
	G

	MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04836
	4768 CERTIFICATE OF DEATH Reg. Dist. No. 223
ly.	1. PLACE OF DEATH: 2. USUAL RESIDENCE (HOME) OF DECEASED:
y and legibly	COUNTY Montgomery MARYLAND STATE Maryland COUNTY Montgomery CITY (If outside corporate limits, write RURAL LENGTH OF STAY (in this place) TOWN Akona Park 1 days HOSPITAL OR STREET (If rural give location)
learl	Mostitution or Washington Janitarium P Address Richie Que.
death clearly	3. NAME OF (First) (Middle) (Last) 4. DATE (Month) (Day) (Year) DECEASED: OF DEATH: 5 - 24 - 1955
causes of	5. SEX: 6. COLOR OR RACE: 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): 9. AGE last birthday 17 UNDER 1 VEAR Hours Min.
the	13. FATHER'S NAME: 14. MOTHER'S MAIDEN NAME:
te	Dimmy Dugan Hanara Doyle
write	15. WAS DECEASED EVER IN U.S. ARE TO FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT & ADDRESS:
please	18. MEDICAL CERTIFICATION RECORD
ole	I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
	332 X IMMEDIATE CAUSE (A) Pulmonary of Cerebral Sufarction 3 mkg
important. Physicians	ANTECEDENT CAUSE (8) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DIF TO
t. Ph	STATING UNDERLYING CAUSE LAST. (C) Rt. Posterior Cerebral entery " 3 uks
ortan	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. POUCLUPEUM 3 44
	19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY?
especially	21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, factory. OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., etc. INJURY OCCUR? (State)
is esp	21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED 21F. HOW DID INJURY OCCUR? While Not while at work at work
age	22. I hereby certify that I attended the deceased from all 15, 1957, to Mog 24, 1957, that I last saw the deceased alive on Mog 24, 1954, and that death occurred at 4.40 M, from the causes and on the date stated above. SIGNATURE DATE SIGNED
correct	Hamuel & Maligar M. D. Not Rainer We 5/5/55 23. BURIAL, CREMATION DATE THEREOF NAME OF CEMETERY OF CREMATORY LOCATION (City, town, or county) (State)
	Burial 5/27/55 Ft. Lincoln Cemetery Prince Geo. County, Md.
	PATE REC'D BY LOCAL REDISTRAN'S ASIGNATURE 24. FUNERAL DIRECTOR 8434 Ga. AVE.
	, , , , , , , , , , , , , , , , , , ,

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. L.

2361 48 YAM

4778
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MARYLAN	D STATE DEPAR	TMENT OF H	EALTH—BALTI	MORE,	18 (iles Fift.
MEDICAL	EXAMINE	R'S CERT	TIFICATE	OF	DEATH	No. 2/3

I. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery MARYLAND	STATE Md COUNTY P. G.	
CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give negrest town) (in this place)	CITY (If outside corporate limits write RURAL and OR	give nearest town)
2 TOWN Kockvelle 3 hrs	TOWN Mt. Ramer	16 - 16 da
HOSPITAL OR INSTITUTION OR TO A CARLO	STREET (If rural, give location)	,
STREET ADDRESS / 02 / Street Cutz	1 3407 Newton 8	,
3. NAME OF (First) (Middle)	(Last) 4. DATE (Month) (Day)	
(Type or Print) Ellanor Jullagher Ne	chilson DEATH May 27	1953
5. SEX: 6. COLOR OR RACE: WIDOWED, DIVORCED, (Specify): Chronical 8	9. AGE last birthday: F UNDER I YI	
work done during most of work life, even if retired): Tralecule muring most of work life, even if retired:	R 11. BIRTHPLACE (State or foreign country): 12.	CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	
mpnoron	mpnom	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY No.:	IN INDODUANT & ADDDESS.	
(Yes, no, or unk.) (If Yes, give war or dates of No Unknown	Harmi Nesholam - Hum an De	/
	AL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
Immediate course (a) Cironary o	erlusion	Sudden
Immediate cause (a) COOMACY		Near
Antecedent cause(s)		recarn
Diseases or conditions, if any. (b)		
glving rise to the above cause DUE TO stating underlying cause last		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING		1
TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes □ No ☑
21a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING OF Street, office bldg., etc. INJURY	, 21c. (City or town) (County)	(State)
21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED OF While at Not while INJURY M. work ☐ at work ☐	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains descri	hed above, held an Autopsy I. Inspection I.	Inquiry M. and
find that death resulted from: Natural causes [], Accid	dent []. Suicide []. Homicide []. Undeter	mined cause []
SIGNATURE	CHIEF MEDICAL EXAMINER	DATE SIGNED
Trank & Breechart	M. D. ASSISTANT MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.	5-27-3-5
23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETER	RY OR CREMATORY LOCATION (City, town, or con	anty) (State)
Burial (Specify)() 5-31-55 Parklawn		yland
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REG. 5/31/55 Lawell A. Traglorp	NER LORESTOR Bethes	address ada, Md.

M MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

BECENTED

BUREAU V. S.

SSCI T NOT

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4769 CERTIFICA	TE OF DEATH Re	g. Dist. No. 8383		
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DE	2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY MONTGOMERY MARYLAND	STATE Maryland COUNTY	montgomery		
CITY (If outside corporate limits, write RURAL) LENGTH OF S	STAY CITYII outside corporate limits, write R			
OR and give nearest town) (in this place	TOWN -	27		
HOSPITAL OR	STREET (II rural give	location)		
INSTITUTION OR	ADDRESS	*		
10 STREET ADDRESS WO Shington Dan & Hespi				
3. NAME OF (First) (Middle)	(Last) 4. DATE (Month OF	(Day) (Yesr)		
(Type or Print)	MIXON DEATH: MA			
5. SEX: 6. COLOR OR 7. SINGLE, MARRIED 8. E	DATE OF BIRTH: 9. AGE last birthday IF	onths Days Hours Min.		
male white (Specify): married ?	3-26-95 60 yrs.			
OA USUAL OCCUPATION (Give kind of work done during most of working life. OR INDUSTRY:		12. CITIZEN OF WHAT		
even if retired): Loan Spec Dept. agric,	14. MOTHER'S MAIDEN NAME:	4.5.		
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:			
John A. Nixon	Mary ann Perry			
(15. WAS DECEASED EVER IN U.S. ARMED FORCES: (Yes., no, or unk.) (If Yes, give war or dates of service)	mrs. Thelma Carlisle My	n-Silver Spins		
18. MEDICAL CERTIF	FICATION	INTERVAL BETWEEN		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		ONSET AND DEATH		
465 1	- 4 4 to	3 moull		
IMMEDIATE CAUSE (A)	MG	0 77477		
ANTECEDENT CAUSE (S'	2.0.0			
GIVING RISE TO THE ABOVE CAUSE DUE TO	nonay model	Lacey		
STATING UNDERLYING CAUSE LAST.				
(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
194. DATE OF OPERATION: 198. MAJOR FINDINGS OF OPER	ATION	20. AUTOPSY?		
		YES NO		
21a. ACCIDENT WAS UNDERLYING OF CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	n, factory. bldg., etc. 1NJURY OCCUR? (City or town)	(County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCU While Not while at work at work	le 🦳			
22. I hereby certify that I attended the deceased from	on , 1951, to May 21, 195), the	it I last saw the deceased		
alive on May 26, 1955, and that death occurre	ed at 150A M, from the causes and on the ADDRESS	DATE SIGNED		
23. BURIAL, CREMATION DATE THEREOF NAME OF CITY SEMOVAL (PECIFY) 5-29-55	Marker Seleish	toyn or county) State)		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS		

BECEINE

BUREAU V. S.

1955 S 1955

MARYLAND STATE DEPARTMENT OF HEALTH

4847

2411 N. Charles Street, Baltimere

CERTIFICATE OF DEATH

Reg. Dist. No.

2. USUAL RESIDENCE (HOME) OF DECEASED. I. PLACE OF DEATH. country COUNTY STATE Maryland Montgomery MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest 30 Per Spring Si (in this place) CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS STREET ADDRESS 815 Richmond Avenue 815 Richmond Avenue 3. NAME OF (First) (M)ddle) (Last) 4. DATE (Month) DECEASED Sallie Palmer Ann May DEATH (Type or Print) 7. SINGLE, MARRIED, WIDOWED, WIDOWED, WILCOWED, (Specify) 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE last birthday | If under I year | If under 24 hrs. Months | Days | Hours | Mln. March 16,1872 11. BIRTHPLACE (State or foreign country) 10s. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OF 12. CITIERN OF WHAT done during most of working life, even if retired)
HOUSEWIIE INDUSTRY home COUNTRY!A Tennessee 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Eliza A. Jones Milton A. Morris 15. WAS DECRASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT AND ADDRESS (Yes, no or unknown) | (If yes, give war or dates of Barber C. Palmer. Silver Spring. Md. None 18. MEDICAL CERTIFICATION INTERVAL BETWEE I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH ONERT AND DEATH Pneumonitis - Pulmonary Edema days Immediate cause Antecedent cause(s) Chronic myocarditis - hypertension - cardio-15 years Diseases or conditions, if any, vascular-renal disease. giving rise to the above cause stating the underlying cause last 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 198. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? None Yes [No M PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY 21. ACCIDENT (Specify) (CITY OR TOWN) (COUNTY) (STATE) SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED HOW DID INJURY OCCUR? While at Not While INJURY Work 22. I hereby certify that I attended the deceased from Oct. 19 33 to May 25 19 55 that I last saw the deceased 12:15 P.m., from the causes and on the date stated above. May 25 19. 55 and that death occurred at... alive on. (Degree or title) SIGNATURE DATE SIGNED 3805 McKinley St. N.W., Wash. 15, D.C. May 25, 1955. 23. BURIAL CREMATION REMOVAL (Specify) NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) Montgomery County, Md. Colesville Cemetery DATE REC'D BY 24 FUNERAL DIRECTOR umbaccu Silver Spring, Md.

of information carefully. death clearly and legibly. Supply every item write the causes of c MARGIN RESERVED FOR INK. UNFADING t. Physicians: important. PLAINLY, is especially i

S. A15

WRITE

PLEASE

SECEINE.

BUREAU V. E.

The correct age

4949

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

04840

Reg. Dist. No. 2

COUNTY Montgomery MARYLAND	STATE Maryland COUNTY	Montgomery
CITY (If outside corporate limits, write RURAL and LENGTH OF STAY	CITY (If outside corporate limits, write RURAL and give	
56 OR give nascest town) Spring (In this place)	TOWN Silver Spring	56
HOSPITAL OR Montgomery Hills Texaco Servic Street Address Station	STREET (If rural, give location) ADDRESS 9402 Warren Street	/
3. NAME OF (First) (Middle)	(Last) 4. DATE (Month)	(Day) (Year)
(Type or Print) Fred Daniel	Pence DEATH May	19 19 55
6. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 9. AGE last birthday If under	year If under 24 hrs. Days Hours Min.
done dring most of working life even intring Finners Station	II. BIRTHPLACE (State or foreign country) 12 Edinburg, Virginia	CITIZEN OF WHAT
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
Joseph Pence	Lilli Summers	
18. WAS DECRASED EVER IN U.S. ARMED FORCES? [16. SOCIAL SECURITY No. (Yes, no, or unknown) (If yes, give war or dates of no	Mr. Fred J. Pence, 9402 Warren	
18. MEDICAL CE	RTIFICATION Silver Spring	g, Md.
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BRIWEEN ONSET AND DEATH
Immediate cause (a) Coronary as	clusion	Sudden
-		Search
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION		J 20. AUTOPSY?
0		Yes D No Z
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING OF office bldg., etc.) CAUSE OF DEATH.	(CITY OR TOWN) (COUNTY)	
TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED OF While at Nnt while INJURY m. work at work	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an a obtained by said Autopsy, Inspection or Inquiry, find that said dece from: natural causes accident , suicide , homicide	ased died on the dry stated above, and death in my	from the evidence opinion resulted DATE SIGNED
23. BURIAY. CREMATION DATE THEREOF NAME OF CEMETE Trans. & Buriay 5/23/55 Hawkinstown	Cemetery Location (City, town, or county,	Virginia
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REG. 23/55 Frances Sitter	Waxwer 6. Lumphrey 8434 Ge	orgia Ave.

BUREAU V. S.

2361 9S YAM

DECENA ED

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04841

4849

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH.	2. USUAL RESIDENCE (HOME) OF DECEASED COUNTY	, , , , ,
MARYLAND	MARYIANG FORE	deriek
CITY (If outside corporate limits, write RFRAL and OR give nearest town) TOWN CITY (If outside corporate limits, write RFRAL and Inc. of STAY (inc. this place)	CITY (If outside corporate limits, write RURAL and giv	e nearest town)
HOSPITAL OR	STREET (If rural, give location)	12016
O INSTITUTION OR STREET ADDRESS	ADDRESS	10X-12
3. NAME OF (First) (Middle)	(Last) 4. DATE (Month)	(Day) (Year)
DECEASED (Type or Print)	Voole DEATH MAY	12 1947
6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVERCED, (Specify) WIDOWED	8. DATE OF BIRTH 9. AGE last hirthday If funder Months	
10a. USUAL OCCUPATION (Give kind of work 10b. Kind of Business on	II. BIRTHPLACE (State or foreign country) 12.	Crandon on Syr
done during most of working life even if retired) INDUSTRY	MARY/ANG	COUNTRY? OF WHAT
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
JOHN T. POOLE	MARGARET TARVER	
15. WAS DECRASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY No. (Yes, no, or unknown) (1f yes, give war or dates of	17. INFORMANT AND ADDRESS	,
Service) NONE	MRS. JERLING BIACK LAMA.	5045, Md.
I8. MEDICAL CEI		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN
	A THE RESERVE TO A STREET OF THE PARTY OF TH	ONSET AND DEATH
Immediate cause (a) Corebral hem	unnhadt.	5 hours
Immediate cause	0140.7	1.90.00
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	diovascular disesse	10 years.
		'
II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street,	(CITY OR TOWN) (COUNTY)	Yes No
SUICIDE OF office bldg., etc.) HOMICIDE INJURY	(COUNTY) (COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED	HOW DID INJURY OCCUR?	
OF INJURY m. While at Not While Work At work		
44	(4 11)	
22. I hereby certify that I attended the deceased from	, 19.75, to MM/12, 19.75., that I last sa	w the deceased
alive on May 1.5. 1925, and that death occurred at 4.	from the causes and on the date sta	tol about
SIGNATURE (Qegree or title)	ADDRESS	DATE SIGNED
Jemes J. Korr. M. M.	1) 11 11 11 11 11 11 11 11 11 11 11 11 1	117166
The things of th	xommun //	7/16/77
23. BURIAL, CREMATION DATE THEREOF NAME OF CEMETER	Y OR CREMATORY LOCATION (City, town, or county	(State)
CREMOVAL (Specify) 5-15-1955 WINGAN	one prederict	my
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
may 12, 1855-1 Della CV. 13 walle	Lill Walt wm /illy	- mg.

DECEDVED MAY 18 1955

BUREAU V. S.

MARGIN RESERVED FOR BINDING

A15-

VS.

04842 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4850 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:
county Montgomery MARYLAND	state Virginia county Arlington
CITY (If outside corporate limits, write RURAL) LENGTH OF STAY	CITY(If outside corporate limits, write RURAL and give nearest town)
X TOWN Bethesda Rural (in this place)	TOWN Arlington 83 x 3
HOSPITAL OR	STREET (If rural give location)
5/street address U. S. Naval Hospital	ADDRESS 2510 16th Street
	(Last) 4. DATE (Month) (Day) (Year)
DECEASED: (Type or Print) Janet Cook	PORTER OF DEATH: May 1 19 55
RACE: WIDOWED, DIVORCED,	9. AGE last birthday 1
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None	11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT COUNTRY? California USA
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Robert C. PORTER	Sylvia CONANT
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) —	Father: Robert C.PORTER 2510 16th
18. MEDICAL CERTIFICAT	N. Arlington, Virginia
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
751111	1 do 1 do 1 do 1 do
	1 thranbo embolism I day
ANTECEDENT CAUSE (S)	10 / - lo : Suduce of the Du
DISEASES OR CONDITIONS, IF ANY. (B)	le bacterial Endocardité 2 mo
STATING UNDERLYING CAUSE LAST.	I A blood Drang Dr
(c) CM 90L	ALTON THUT GISCOSE 10/MO
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE	
DISEASE OR CONDITION CAUSING DEATH	N O AUTORIO
2	20. AUTOPSY? YES X NO
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, factor CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., (IF EITHER, NOTIFY MEDICAL EXAMINER)	, etc. INJURY OCCUR?
OF INJURY (Day) (Year) (Hour) 21E INJURY OCCURRED While While at work at work	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 28 A	pr 1955, to 1 May 1955, that I last saw the deceased
	12:45M, from the causes and on the date stated above.
	eal, NNMC, Bethesda, Md. 1 May 1955
23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETI	ERY OR CREMATORY LOCATION (City, town, or county) (State)
Burial 5 May 1955 Columbia C DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR	emetery Arlington, Virginia 21VES FUNERAL HOME 2847 Wilson Blvd.
5-1-55 Mary G. Farrelly	Arlington, Virginia

BECEINED

2361 **6 YAM**

BUREAU V. S.



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DECENED A

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VS. A15.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04844

852 CERTIFICATE OF DEATH

Reg. Dist. No. 2/8

	400% CERTIFICATE	Reg. Dist. No. 64/ 0
ly.	1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:
legibly	COUNTY MONTGOMERY MARYLAND	STATE MARYLANDCOUNTY PRINCE (15-1855-
le	CITY (If outside corporate limits, write RURAL LENGTH OF STAY	CITY(If outside corporate limits, write RURAL and give nearest town)
and	OR and give nearest town) TOWN TERMANTOWN MB (in this place)	TOWN MT. RAINIER 16-16-2
	HOSPITAL OR INSTITUTION OR	STREET (If rural give location) ADDRESS
clearly	90 STREET ADDRESS LNSTITUTION MARYLANDER	7326 3/2 ST,
	DECEASED:	(Last) 4. DATE (Month) (Day) (Year)
death	5. SEX: 6. COLOR OR 7. SINGLE, MARRIED. 8. DATE	OF BIRTH: 8 9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS.
of (RACE: WIDOWED, DIVORCED, (Specify): 4/15 COLUMN TEED	15 ' PO' 1 - O Months Days Hours Min.
	TOA. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS	11 BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT
causes	work done during most of working life. OR INDUSTRY:	COUNTRY
	13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
the	10.10.10.10	Time Cilania
te	J.W. MIDRPHY	JULIA SHRIVER
write	15. WAR DECEASED EVER IN U.S. ARMED FORCEST (Yes, No. of unk.) (If Yes, give war or dates	17. INFORMANT & ADDRESS:
Se	of service)	HOME LECORDS
please	18. MEDICAL CERTIFICAT I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	ION INTERVAL BETWEEN ONSET AND DEATH
D ₁		A A A
18:	IMMEDIATE CAUSE (A) Interior let	the cardiovascular desease 5 years
Physicians	ANTECEDENT CAUSE (S)	
ysic	DISEASES OR CONDITIONS, IF ANY. (B)	
Ph	GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST.	
	(C)	
tan	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE	
or	DISEASE OR CONDITION CAUSING DEATH.	
important.	19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES NO
especially	21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fact OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., (IF EITHER, NOTIFY MEDICAL EXAMINER)	
Sp	21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
is	OF INJURY While M. While at work	
96	22. I hereby certify that I attended the deceased from	J., 1955, to May, 1955, that I last saw the deceased
ಪ	alive on May 3, 1955, and that death occurred at	3-45 9M, from the causes and on the date stated above.
correct	SIGNATURE	ADDRESS DATE SIGNED
orr		.o. Homaseus, Md. May 1, 1955
Ú	23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETE	ERY OR CREMATORY LOCATION (City, town, or county) (State)
	KEMOVIC	MIT, KAINER, MD-
	DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS

DECENTED

BUREAU V. S.

3361 91 YAM

Supply every item of information carefully. The

PLAIMLY, WITH UNFADING INK.

PLEASE TYPE OR WRITE

VS. A15-

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with.	0	U	-

MARYLAND	STATE	DEPARTMENT	OF	HEALTH-	-BALTIMORE,	18	0484	1
		DANTEST CLA ANTE					2	

CERTIFICATE OF DEATH

Reg. Dist. No. 2/7

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:
county Montgomery MARYLAND	STATE Maryland county Montgomery
CITY (If outside corporate limits, write RURAL LENGTH OF STAY	CITY(If outside corporate limits, write RURAL and give nearest tow
OR and give nearest town) (in this place) X TOWN Olney l day	OR TOWN Torrham gazilla
	STREET (If rural give location)
HOSPITAL OR Montgomery County STREET ADDRESS General Hospital, Inc	ADDRESS
3. NAME OF (First) (Middle) (DECEASED:	Last) 4. DATE (Month) (Day) (Year)
	Riordan DEATH: May 13 19 55
RACE: WIDOWED, DIVORCED,	OF BIRTH: 9. AGE last birthday IF UNDER 1 YEAR HOURS Min Months Days Hours Min
OA. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith	11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT COUNTRY? Maryland U.S.A.
13. FATHER'S NAME:	Maryland U.S.A.
Daniel Riordan	Catherine Costello
5. WAR DECEASED EVER IN U.S. ARMEO FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	17. INFORMANT & ADDRESS:
18. MEDICAL CERTIFICAT	Hospital Record INTERVAL BETWEE
DISEASES OR CONDITIONS, IF ANY. GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) OUL TO DUE TO	derotic/teart Direan him
(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE	
DISEASE OR CONDITION CAUSING DEATH.	
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSYT
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fact of CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, fact of UNJURY street, office bldg., office	ory. 21c. WHERE DID (City og town) (County) (State) etc. INJURY OCCUR? (County) (County) (State) (State) (County) (Count
alive on May 13, 1953, and that death occurred at SIGNATURE	6:18M. from the causes and on the date stated above. ADDRESS DATE SIGNED Y, Lig, Nay 14, 3
23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETE	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	RY OR CREMATORY LOCATION (City, town, or county) (State of the cou

DECEIVED MAY 20 1955

BUREAU V. S.

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DECELVED 1955

BUREAU V. S.

4954

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

reet, Baltimore 04847

CERTIFICATE OF DEATH

Reg. Dist. No. 2/9

	,	
I. PLACE OF DEATH	2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY Han Gamery MARYLAND	STATE COUNTY	Number
CITY (If outside corporate limits, write RUPAL and LENGTH OF STAY	CITY (If outside corporate limits, write RURAL and giv	e nearest town)
OR give nearest town) OR TOWN (in the place)	TOWN Selves forme	56
HOSPITAL OR	STREET (If rural give location)	00
INSTITUTION OR 1953 Seminary Kg.	ADDRESS 1953 Seminary	Ma.
3. NAME OF (First) (Middle)	(Last) 4. DATE (Month)	(Day) (Year)
Type or Pulity Mullia	herger DEATH Man	25 1953
S. SEX 6. COLOROR PACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED	8. DATE OF BIRTH 9. AGE last birthday If under Months	
(Specify) 10a/USUAL OCCUPATION (Give kind of work 10h, Kind of Business or	, J.	Comment
done during most of working life, even if retired INDUSTRY	11. BRTHPLACE (State or foreign country) 12	COUNTRY?
3. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
Frank lewher.	Hernachul Koh	man.
5. Was Deceased Ever In U.S. Armed Forces? 16. Social Security No. Yes, no, or unknown) [(If yes, give war or dates of	17. INFORMANT	
service)	Mus D. Therge	七.
18. MEDICAL CE	RTIFICATION	
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
422,2	5 1	1 00
Immediate cause (a)	Con to am	1 aay
Antecedent cause(s)	1111	1 //
Diseases or conditions, if any, (b)	y ocardeles aux, poulle	+ 16 MID
giving rise to the above cause stating the underlying cause last		
(c) Ten arte	erschions	
OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
9a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
		Yes No No
ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY)	Total Control
HOMICIDE INJURY TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED	HOW DID INJURY OCCUR?	
OF While at Not While	Now DID MISORI OCCOR:	
INJURY m. Work At work	1 15 // -	
22. I hereby certify that I attended the deceased from	19.5, to 5, 19.5, that I last s	aw the deceased
_alive on and that death occurred at		ted shove
SIGNATURE (Degree or title)	ADDRESS	DATE, SIGNED
19. 1 morse on a Dosolar	weller Tahong land had	5/25/55
3. BURIAL, CREMATION DATE THEREOF NAME OF CEMETE	RY OR CREMATORY LOOATION (City, town, or count	y) (State)
wreak (Specify) They 1955 Rock Gree	K (semeterel I pashington.	26.
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	24. FUNERAL PRECTOR	ADDRESS
REG. 27/55 Frances Hotler	Visite Vialions 25tha	roll Star

DECEIVED V. S. V UAARUA

		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18	04848
1.	7. The	· 4855 CERTIFICATE OF DEATH Reg. Dist.	No. 2-14
10	carefully legibly.	1. PLACE OF DEATH: 2. USUAL RESIDENCE (HOME) OF DECEASED	
.4	carefull legibly.	COUNTY MONTGOMERY MARYLAND STATE MC COUNTY MO	ntgumery
1		CITY (If outside corporate limits, write RURAL and give mearest town) OR and give mearest town	d five nearest lown)
	tion	5 TOWN Silver Spring 3. 375 TOWN Silver Spring	19 56
	information	HOSPITAL OR INSTITUTION OR 2700 Hamming Vicence Address (If rural give location)	2 /
	for	postreet address 2700 Harris Evenue 2700 Harris	tre.
	of ir	DECEASED: WA A I DO TO THE OF WAS I BE	(Year)
	m of i	(Type or Print) OVShall HINE 150 Shaller DEATH: 110 D	-S 1935
	ite	RACE: WIDOWED, DIVORCED. NOV. 24 1899 55 yrs. Months Da	
	every	IOA. USUAL OCCUPATION (Give kind of 108 KIND OF BUSINESS 11. DRTHPLACE (State or foreign, country): 12. (SITIZEN OF WHAT
5 Y		even if retired: Auch tee ON INDUSTRY:	COUNTRY?
Tid.	pply the	13. FATHER'S NAME; Chief Office of Technical Service Cothers MAIDEN NAME:	X 3/)
Z		Leigh Shaffer U.S. Public Health Emily Mgc Lea	h
K	K. Su write	15. WAS DECEASED BEER IN U.S. ARMED FORCEST 16. SOCIAL SECURITY NO. 17. INFORMANT & ADDRESS:	
FO	G INI	(Te no, or with.) (If Yes, give war or dates of service) 19175-55 Helen Shaffer - 2700 Hol	115
Q	NG	18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN
ZV.	DI	1/1/2 \	ONSE! AND DEATH
SEI	A W	IMMEDIATE CAUSE (A) Cardioc. HYPES T	
E E	UNF	ANTECEDENT CAUSE (S)	31110
MARGIN RESERVED FOR BINDING	TTH Phys	DISEASES OR CONDITIONS, IF ANY. GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO	-913
AR		(C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING	
M	AINLY, Wimportant	TO THE DEATH BUT NOT RELATED TO THE	
	AINL	19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
			YES NO
7	TE PL ecially	21A. ACCIDENT WAS UNDERLYING \[\) 21B. PLACE (Home, farm, factory. 21c. WHERE DID (City or town) OR CONTRIBUTING \[\] CAUSE OF DEATH OF INJURY street, office bldg., etc. INJURY OCCUR? (County of the county of t	(State)
	WRITE	21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED 21F. HOW DID INJURY OCCUR?	
	R W	M. at work at work	
	0 0	22. I hereby certify that I attended the deceased from 1.10 7.19 5. to 110, 25, 1935, that I last	saw the deceased
53	PE ag	alive on 10.4741955, and that death occurred at 7 AM, from the causes and on the date s	tated above.
10	TYPI	Captell Comments	E SIGNED
I	SE	23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or	county) (State)
A15	EAS	Burial 5/27/55 Arlington Nat'l. Cemetery Arlington, Virg	ginia
4	PLI	DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR	ADDRESS

8434 Ga. Ave. Silver Spring, Md.

VS.

DATE REC'D BY LOCAL

enderson some 10027,1849 = 55 regions near them then the The second of th BUREAU V. S.

VS. A15-

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04849

MARILAND STATE DEFARIMEN.	
4771 CERTIFICATE	C OF DEATH Reg. Dist. No. 223
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:
COUNTY Montgonery MARYLAND	STATE DC COUNTY 47 x -3
CITY (If outside corporate limits write RURAL Corporate limits write RURAL (in this place)	CITY(If outside corporate limits, write RURAL and give nesrest town) OR TOWN WAShington
15 STREET ADDRESS Wash. Sautarium	STREET (If tural give location) ADDRESS 1413 Chittenden St N.W.
DECEASED.	Last). 4. DATE (Month) (Day) (Year) OF DEATH: May 3/ 1955
5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE WIDOWED, DIVORCED, (Specify): Married	OF BIRTH: 9. AGE iast birthday Wonder 1 YEAR 1 F UNDER 24 MRS. Months Days Hours Min.
work done during most of working life even if retired):	RUSS / a 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	Wash San + Hos P Records.
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY. GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	ONSET AND DEATH
(C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING	
TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	(4) - 전 집 역 (4) (6) (6/
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
0	YES NO
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fact OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bidg., (IF EITHER, NOTIFY MEDICAL EXAMINER)	etc. INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while at work at work	21F. HOW DID INJURY OCCUR?
23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETE	AM, from the causes and on the date stated above. ADDRESS DATE SIGNED D. 9 5 2 / 5 5 ERY OR CREMATORY LOCATION (City, town, or county) (State)
Date REC'D BY LOCAL REGISTERAR'S GIGNATURE PRESIDENT 1965 TO THE PRESIDENT OF THE PRESIDENT	24. FUNERAL DIRECTOR Jon Wash. D.C.



BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK.

VS. A15

Supply every item of information carefully. The

4856

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

				Reg. Dis	
1. PLACE OF DEATH:			2. USUAL RESI	DENCE (HOME) OF DECEASE	D:
COUNTY Montgomery	MARYLA	ND	STATE	COUNTY	
CITY (If outside corporate limits, write R OR and give nearest town) TOWN Bethesda	(in t	H OF STAY his place) days	OR	hington, D. C.	and give nearest town
HOSPITAL OR The Clinical			STREET ADDRESS	(If rural give location)
SOSTREET ADDRESS Natl. Instit	utes of He	ealth	354	1 Highwood Dr., S.E	√
3. NAME OF (First) DECEASED:	(Middle)		(Last)	4. DATE (Month)	(Day) (Year)
(Type or Print) Effic	Alma		immonds	DEATH: May	26 1955
5. SEX: 6. COLOR OR 7. SINGLE. WIDOWE (Specify):	MARRIED. ED, DIVORCED, Widowed		of BIRTH:	9. AGE last birthday IF UNDER 1	Days Hours Min.
OA. USUAL OCCUPATION (Give kind of 10m	OR INDUSTR	JSINESS	II. BIRTHPLACE	(State or foreign country): 12.	COUNTRY?
	Governmen	t	Virgini		U.S.A.
13. FATHER'S NAME:			14. MOTHER'S I	MAIDEN NAME:	
George Tavenner			Mary Fr	anklin	
S. WAS DECEASED EVER IN U.S. ARMED FORCES?	16. SOCIAL SECU	JRITY NO.	17. INFORMANT		
(Yes, no, or unk.) (If Yes, give war or dates of service)	577-36-4	785	The medical	record, The Clinic	al Center
)	S. MEDICAL	CERTIFICAT	ION		INTERVAL BETWEEN
DISEASES OR CONDITIONS, IF ANY,	(A) porta	ahepational vein er of bi	reast with me	etastases to liver, eritoneal lymph	ONSET AND DEATH
	(c) nodes	s, and	left carotid	artery	
II OTHER SIGNIFICANT CONDITIONS CO TO THE DEATH BUT NOT RELATED TO T DISEASE OR CONDITION CAUSING DE	THE				
	FINDINGS OF	OPERATIO	V		20. AUTOPSY?
- 21					YES X NO
21A. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH OF (IF EITHER, NOTIFY MEDICAL EXAMINER)	B. PLACE (Hom INJURY street	e, farm, fac , office bldg.,	etc. 21c. WHERE	DID (City or town) (Cour UR?	nty) (State)
2ID. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		OCCURRED	21F. HOW DID	INJURY OCCUR?	
22. I hereby certify that I attended the	e deceased fro	om May	20 1955 to M	av 26 1955 that I les	t saw the deceased
alive on May 26 19.55, and SIGNATURE Bullande Breshow 23. BURIAL CREMATION, DATE THEREO	that death of	ccurred at	6:45pM, from ADDRE The Clini	the causes and on the date is DA cal Center titutes of Health LOCATION (City, town, o	stated above. TE SIGNED 5/27/55 Pr county) (State)
DATE REC'D BY LOCAL REGISTRAR'S REGISTRAR'S	-	1.00	34. FUNERAL	DIRECTOR 1	ADDRESS S.E

BUREAU V. E.

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6)	MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04851
. The	4857 CERTIFICATE OF DEATH Reg. Dist. No. 2/6
Supply every item of information carefully. te the causes of death clearly and legibly.	1. PLACE OF DEATH: COUNTY MONTON MARYLAND CITY (If outside corporate limits, write RURAL LENGTH OF STAY (in this place) OR and give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS 3. NAME OF (First) DECEASED: (Type or Print) TOWN SEX: 6. COLOR OR 7. SINGLE, MARRIED, B. DATE OF BIRTH: RACE: WIDOWED, DIVORCED, B. DATE OF BIRTH: (Specify); AUSUAL RESIDENCE (HOME) OF DECEASED: STATE MAYAND COUNTY MONTON (In this place) CITY(If outside corporate limits, write RURAL and give nearest town) OR TOWN CITY(If outside corporate limits, write RURAL and give nearest town) OR TOWN (If rural give location) ADATE (Month) (Day) (Year) OF DEATH: MARIED, 19-65 SEX: OF DEATH: MONTHS Days Hours Min. IOA. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS) 11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT
A pest	work done during most of working life. OR INDUSTRY: HOLAND 13. FATHER'S NAME: 14. MOTHER'S MAIDEN NAME: 15. WAS DECEASED EVER IN U.S. ARMED FORCEST (Yes, no, or unk.) 11f Yes, give war or dates
ITH UNFADING IN Physicians: please	I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE ANTECEDENT CAUSE (S:) DISEASES OR CONDITIONS, IF ANY. GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (A) (B) (B) (C) (C) (C) (C) (C) (C
AINLY, importal	11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATON 20. AUTOPSY? YES TO NO
PLEASE TYPE OR WRITE PL	21a. ACCIDENT WAS UNDERLYING 21a. PLACE (Home, farm, factory. OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. PLACE (Home, farm, factory. OF INJURY Street, office bldg., etc. INJURY OCCUR? 21c. WHERE DID (City or town) (County) (State) (County) (State) 21c. WHERE DID (City or town) (County) (State) (INJURY OCCUR? (INJURY OCCUR?

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VS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 () 4852

	TE OF DEATH Reg. Dist. No. 212
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED;
COUNTY MONTGOMETY MARYLAND	STATE Virginia COUNTY
CITY (If outside corporate limits, write RURAL) LENGTH OF STA	Y CITY(If outside corporate limits, write RURAL and give nearest town)
OR and give nearest town) TOWN Bethesda Rural (in this place) 3 mo 13 day	ys TOWN Fairfax 83 x - 3
HOSPITAL OR SINSTITUTION OR STREET ADDRESS U. S. Naval Hospital	STREET (If rural give location) ADDRESS 124 Fairview Drive
3. NAME OF (First) (Middle)	(Last) 4. DATE (Month) (Day) (Year)
DECEASED: (Type or Print) George Sanford	SMITH OF DEATH: May 22 19 55
5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DAT	E OF BIRTH: 9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
	-28-15 40 yrs.
OA. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager 10B. KIND OF BUSINESS OR INDUSTRY: Gas Company	11. BIRTHPLACE (State or foreign country): 12, CITIZEN OF WHAT COUNTRY? Maryland US
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
William C. SMITH	Agnes MALONE
(Yes, no, or unk.) (If Yes, give war or dates of service) WW II 217 10 2217	Wile Mrs. Eunice G. Smith
18. MEDICAL CERTIFICA	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	ONSET AND DEATH
86 6 X LYLLUSE (A) LYLLUSE	rsablishoch 5 days
ANTECEDENT CAUSE (S)	
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	iple fat emboli 5 days
(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATI	ON 20. AUTOPSY?
17 may 55-3 non union, nox 1	of fernur YES NO
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, for contributing Cause of Death OF INJURY street, office bidding the contribution of the cont	g., etc. INJURY OCCUR? OH MOTH CARNING COOX
OF INJURY MAN 15 1954 M. 21E INJURY OCCURAR. While at work	FU 21F HOW DID IN MARY OCCUR?
22. I hereby certify that I attended the deceased from 22 M	by, 19.55 to 22 May, 19.55 that I last saw the deceased
	at 12:15 A, from the causes and on the date stated above. ADDRESS DATE SIGNED
23. BURIAL, CREMATION, DATE THEREOF NAME OF CEME	Memorial Cemetery Wicomico Co, Maryland (State)
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE PREGISTRAR 1955 Day 6. Janelle	R4 A DDRESS 7557 Wisconsin Avenue, Bethesda, Maryland
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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Reg. Dist. No.

	CATE OF DEATH		. No. 217
I. PLACE OF DEATH:	2. USUAL RESIDENCE	CE (HOME) OF DECEASE	D:
county Montgomery MARYLAND	state Maryla	and county Mo:	ntgomery
CITY (If outside corporate limits, write RURAL LENGTH (in this	OF STAY CITY(If outside cor	rporate limits, write RURAL s	and give nearest town)
X TOWN Bethesda Rural 1 day	Town Silver	Spring	56
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital	STREET ADDRESS 12611	(If rural give location) Bushey Drive	/
3. NAME OF (First) (Middle)	(Last)	4. DATE (Month) (Day) (Year)
(Type or Print) Kendall Joseph	SMITH	DEATH: May	11 19 55
5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	9. DATE OF BIRTH: 9. A	AGE last birthday IF UNDER 13	Pays Hours Min.
OA. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None	INESS 11. BIRTHPLACE (Sta	ate or foreign country): 12.	
3. FATHER'S NAME:	14. MOTHER'S MAID		
Floyd G. SMITH	Ursula B. HA	AUSER	
(Yes, no, or unk.) (If Yes, give war or dates of service)	rv No. 17 INFORMANT & A Father Mr. F Same as abov	Tloyd G. SMITH	
ANTECEDENT CAUSE (\$)			ONSET AND DEATH
GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST.			
(C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING			
TO THE DEATH BUT NOT RELATED TO THE			
DISEASE OR CONDITION CAUSING DEATH. 19a. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OR	PERATION		20. AUTOPSY?
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, DR CONTRIBUTING CAUSE OF DEATH OF INJURY street, of the contribution of the con	farm, factory, ffice bldg., etc. 21c. WHERE DID INJURY OCCUR?	(City or town) (Count	ty) (State)
21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OF While Not at work at w	while	URY OCCUR?	
22. I hereby certify that I attended the deceased from	10 May, 1955, to 11	May, 19.55 that I last	saw the decease
alive on 11 May , 19.55, and that death occursions of the MC USN U. S. Nava	urred at 4:45AM, from the ADDRESS	causes and on the date DATE thesda, Maryland	stated above. re signed
23. BURIAL, CREMATION, DATE THEREOF NAME OF	F CEMETERY OR CREMATORY	LOCATION (City, town, or	county) (Stat

(City, town, or county)

REMOVAL (SPECIFY) 16 May 1955 Arlington National Cemetery Arlington, Vir ginia Burial REGISTRAR'S SIGNATURE DATE REC'D BY LOCAL

24. FUNERAL DIRECTOR UNDER ADDRESS R. A. Pumphrey Funeral Home ADDRESS 7557 Wisconsin Avenue, Bethesda, Md. REGISTRAR 12 May 1

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ARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE I. PLACE OF DEATH: 2. USUAL RESIDENCE (HOME) OF DECEASED: Maryland Montgomery Montgomery COUNTY COUNTY MARYLAND STATE LENGTH OF STAY CITY (If outside corporate limits write RURAL and give nearest town) CITY (If outside corporate limits, write RURAL OR TOWN Bethesda, Maryland OR and Be the sda (Rural) tim this place) HOSPITAL OR (If rural, give location) INSTITUTION OR Tolo Clarendon Road STREET ADDRESS U.S. Naval Hospital (Year) (First) (Middle) (Last) 3. NAME OF 4. DATE (Month) DECEASED: May SMITH Truitt Norman DEATH (Type or Print) 19 5. SEX: 8. DATE OF BIRTH: 6. COLOR OR 7. SINGLE. MARRIED. 9. AGE last birthday: | IF UNDER 1 YEAR IF UNDER 24 HRS. WIDOWED DIVORCED (Specify): Married Ma.le WASte 58 Days Months 3 Mer 10a. USUAL OCCUPATION (Give kind of 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WILAT work done during most of work life, even if retired): Postal clerk INDUSTRY: COUNTRY? Howard County, Maryland Retired US 14. MOTHER'S MAIDEN NAME: 13. FATHER'S NAME: VIRGINIA SHIPLEY ANTHONY SMITH 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT & ADDRESS: Wife Mrs. Miriam O. SMITH 16. SOCIAL SECURITY No.: (Yes, no, or unk.) (If Yes, give war or dates of service WWI 6-6-19 Unknown Same as above 18. MEDICAL CERTIFICATION INTERVAL BETWEEN I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: ONSET AND DEATH oronary orchises Immediate cause DUE TO Antecedent cause(s) (b) ... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 19a. DATE OF OPERATION: | 19b. MAJOR FINDING OF OPERATION: 20. AUTOPSY? Yes 🔯 No 🗌 (County) 21a. EXTERNAL CAUSE WAS 21b. PLACE (Home, farm, factory, 2Ic. (City or town) (State) PRIMARY | or CONTRIBUTING | CAUSE OF DEATH. OF street, office bldg., etc., 21e. INJURY OCCURRED 21f. HOW DID INJURY OCCUR? 21d. TIME (Month) (Day) (Year) (Hour) While at Not while INJURY work [at work 22. I hereby certify that I took charge of the remains described above, held an Autopsy [], Inspection [], Inquiry [], and find that death resulted from: Natural causes [, Accident [, Suicide [, Homicide [, Undetermined cause [] . CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER DATE SIGNED SIGNATURE ASSISTANT MEDICAL EXAM. 23. BURIAL, CREMATION. NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) DATE THEREOF 31 May 1955 Arlington National Cemetery Arlington. Virginia ADDRESS DATE REC'D BY LOCAL LREGISTRAR'S SIGNATURE 7557 Wisconsin Ave. Bethesda, Maryland

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MARYLAND	STATE	DEPARTMENT	OF	HEALTH—BALTIMORE,	18	04856
2		A TOTAL COLUMN				02000

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	4862 CERTIFICATI	E OF DEATH Reg. Dist. No. 215
and legibly.	1. PLACE OF DEATH: COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: District of Cloumbia STATE COUNTY
ol bu	CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) (in this place)	CITY(If outside corporate limits, write RURAL and give nearest town)
death clearly an	X TOWN Bethesda - Rural 11 Hrs.26Min HOSPITAL OR SISTREET ADDRESS II C Newel Hospitel	STREET (If rural give location) ADDRESS
cle	U.D. NEVEL HOSPILET	(Last) 637 5th Street, N.E. (Day) (Year)
ath	DECEASED: (Type or Print) August Otto ST	PARKE DEATH: May 5 19 55
of de	5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, RACE: WIDOWED, DIVORCED.	OF BIRTH: 9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 21-77 77 yrs. Months Days Hours Min.
causes	Male Caucasian Gipedity: Married 11-2 10A. USUAL OCCUPATION (Give kind of 10B KIND OF BUSINESS OR INDUSTRY: even Civered Service US Govt Retired	11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT COUNTRY? Washington, D.C. U. S.
	13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
e th	Albert STARKE	Mary ADAMS
e write the	(Yes, no, or unk.) (If Yes, give war or dates Yes Of serve panish American Unknown	17. INFORMANT & ADDRESS: Wife Mrs. Lola Starke Same as above
important. Physicians: please	IB. MEDICAL CERTIFICAT I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE	pulmonary lalema Interval BETWEEN ONSET AND DEATH I day I will condition with a service of the s
por	DISEASE OR CONDITION CAUSING DEATH.	
	198. MAJOR FINDINGS OF OPERATION	N 20. AUTOPSY? YES NO X
especially	21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fact OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., (IF EITHER, NOTIFY MEDICAL EXAMINER)	ctory. 21c. WHERE DID (City or town) (County) (State)
is esp	21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while at work at work	
correct age i	C. S. STROUD COR MC USN U. S. Naval Hospini 23. BURIAL, CREMITION, DATE THEREOF NAME OF CEMETI	10.46 P M, from the causes and on the date stated above. ADDRESS DATE SIGNED

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(Year)

19 5

IF UNDER 24 HRS.

INTERVAL BETWEEN

ONSET AND DEATH

20. AUTOPSY? YES T

(County)

TION (City, town, or county)

DATE SIGNED

ADDRESS

NO

State

(State)

(Day)

Days

COUNTRY2

(Month)

Reg. Dist. No.

2. USUAL RESIDENCE (HOME) OF DECEASED

M. D

NAME OF CEMETERY OR CREMATORY

FUNERAL

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

MARGIN RESERVED FOR BINDING

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. The	4864 CERTIFICATI	E OF DEAT	H Reg. Dist	No. 215	
ully.	1. PLACE OF DEATH:	2. USUAL RESIDEN	ICE (HOME) OF DECEASED	D:	
item of information carefully.	COUNTY Montgomery MARYLAND CITY (If outside corporate limits, write RURAL LENGTH OF STAY (in this place)	OR	rporate limits, write RURAL	nd give nearest town)	
tion	X TOWN Bethesda Rural 18 days	TOWN Key West 48 X - 3			
nforma	HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital	STREET ADDRESS 618 W	(If rural give location) hite Street	/	
of in	3. NAME OF (First) (Middle) DECEASED: T	(Last) URRENCY	OF	Oay) (Year) 25 19 55	
TH UNFADING INK. Supply every item of i	5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, RACE: WIDOWED, DIVORCED. 8. DATE		AGE last birthday Ir UNDER I V Months D		
	10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (St. Florida	ate or foreign country): 12.	COUNTRY?	
	13. FATHER'S NAME:	14. MOTHER'S MAI			
	John C. SURRENCY	Gail SWEETING			
	(Yes, no, or unk.) (If Yes, give war or dates of service)	Father John Same as abov	C. SURRENCY CPL U	SMC	
	I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY. (B)	Ralus, Cong.	wital	INTERVAL BETWEEN ONSET AND DEATH	
H	STATING UNDERLYING CAUSE LAST. DUE TO				
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING		. 111	, ,	
LY	TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	itis of Veestre	ceclifia	14 days	
PLAINLY, W	19a. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 5-11-55 3 Conquerital hydrocep			20. AUTOPSY?	
	21A. ACCIDENT WAS UNDERLYING OF COUNTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, office bldg., etc. INJURY OCCUR? (State)				
	21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED 21F. HOW DID INJURY OCCUR? While Not while at work at work				
correct/age	22. I hereby certify that I attended the deceased from 7 May , 19 55, to 25 May, 19 55, that I last saw the deceased above on 25 May . 19 55, and that death occurred at 8.554M, from the causes and on the date stated above. DATE SIGNED W. MACKIE LCDR MC USN U. S. Naval Hospital, NNMC, Bethesda, Maryland 23. BURIAL. GREMATION. DATE THEREOF NAME OF CEMETERY OR GREMATORY LOCATION (City, town, or county) Burial 29 May 1955 Private Cemetery Key West Florida				
PLEA	DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR 26 May 1955 Pary 6. ranelly	R4. AUNIPANDE	Regranderal Home sin Avenue, Bethes	ADDRESS	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0486.1<sub>Dist.</sub>

| MEDICAL EXAMINER'S CERT | TIFICATE OF | DEATH | No. 4 |
|-------------------------|-------------|-------|-------|
|-------------------------|-------------|-------|-------|

| orrect                                                           | MEDICAL EXAMINER'S CER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | TIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | No. 223                                       |  |
|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|--|
| ن<br>پ                                                           | I. PLACE OF DEATH:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                               |  |
| ly.                                                              | COUNTY MONTGOMERY MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STATE Penna, COUNTY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                               |  |
| fully.<br>legib                                                  | CITY (If outside corporate limits, write RURAL OR and give pearest town) TOWN Takoma Park                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | CITY (If outside corporate limits write RURAL and OR TOWN York                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1 give nearest town)<br>75×-3                 |  |
| y and                                                            | HOSPITAL OR STREET ADDRESS Washington Sanitarium & Hospitalium                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET (If rural, give location) ADDRESS ADDRE | 1                                             |  |
| natio                                                            | 3. NAME OF (First) (Middle) DECEASED: (Type or Print) John Ziegler St                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (Last) 4. DATE (Month) (Day<br>OF<br>DEATH 5 22                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (Year)<br>19 55                               |  |
| of information carefully. The correct death clearly and legibly. | 5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DAT RACE: WIDOWED, DIVORCED, (Specify): Separated 7.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | E OF BIRTII: 9. AGE last birthday: FUNDER I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                               |  |
| y every item of<br>the causes of d                               | IOa. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Salesman  Separate Se | II. BIRTHPLACE (State or foreign country): 12.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | CITIZEN OF WHAT COUNTRY?                      |  |
| ite                                                              | 13. FATHER'S NAME:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                               |  |
| cau                                                              | William B. Sweitzer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Lemanda Ziegler                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                               |  |
| ev.                                                              | 15. Was Deceased Ever In U.S. Armed Forces ? (Yes, no, or unk.) (If Yes, give war or dates of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 17. INFORMANT & ADDRESS:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                               |  |
| Supply<br>write tl                                               | No service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Hospital Records.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                               |  |
| INK.<br>lease                                                    | I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  Immediate cause  (a) Corrary  DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | orclusion                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | INTERVAL BETWEEN ONSET AND DEATH              |  |
| UNFADING<br>Physicians: p                                        | Antecedent cause(s)  Diseases or conditions, if any, giving rise to the above cause DUE TO  stating underlying cause last (c)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ·                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | erverse.                                      |  |
| t. Ph                                                            | II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                               |  |
| E PLAINLY WITH especially important.                             | 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 20. AUTOPSY? Yes   No                         |  |
| LY<br>M                                                          | 21a. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING OF Street, office bldg., etc INJURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Co,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (State)                                       |  |
| LAIN                                                             | 21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED While at Not while INJURY M. Work at work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                               |  |
| WRITE Pl                                                         | 22. I hereby certify that I took charge of the remains descrifted that death resulted from: Natural causes A, Accisionature  June Branch Branchart                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ibed above, held an Autopsy [], Inspection sident [], Suicide [], Homicide [], Undete CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | , Inquiry ②, and rmincd cause □.  DATE SIGNED |  |
| PLEASE ag                                                        | 23. BURIAL, CREMATION DATE THEREOF NAME OF CEMETE REMOVAL Specify:  May 24, 1955  OFFERECO BY LOCAL REMETANTS SUNATURE  1999 1 2 4 9 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Genetify Location (City, town, or confidence of the Freshon, York (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 0 (1)                                         |  |
| 14                                                               | May by Joak & Correst Of Contraction                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1.04610                                       |  |

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

| MEDICA | LITE | XAMIN | TER'S | ERTIFICAT | TO ST | DEATH |
|--------|------|-------|-------|-----------|-------|-------|
|        |      |       |       |           |       |       |

| MEDICALITEXAMINER STEER                                                                                               | TIFICATE OF DEATH                                                            | No. 213                          |
|-----------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------|
| 1. PLACE OF DEATH:                                                                                                    | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                       |                                  |
| COUNTY MONTAMORY MARYLAND                                                                                             | STATE Ind COUNTY Monta                                                       | -                                |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)  TOWN  LENGTH OF STAY (in this place)        | CITY (If outside corporate limits write RURAL and OR TOWN Rockwills          | give nearest town)               |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hosp.                                                              | STREET ADDRESS R 7. 0 = (If rural, give location)                            | rel)                             |
| 3. NAME OF (First) (Middle) DECEASED: (Type or Print) Herman                                                          | Last) 4. DATE (Month) (Day OF DEATH May 22                                   |                                  |
| male RACE: WIDOWED, DIVORCED, (Specify) & arried apa                                                                  | F OF BIRTH: 9. AGE iast birthday: 4 UNDER 1 Y                                |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) INDUSTRY:                    | R   II. BIRTHPLACE (State of foreign country):   12.                         | COUNTRY?                         |
| 13. FATHER'S NAME: J. Thomas                                                                                          | 14. MOTHER'S MAIDEN NAME;                                                    |                                  |
| 15. Was Deceased Evar In U.S. Armed Forces? (Yes, no, or unk.) (If Yes, give war or dates of service)                 | 17. INFORMANT & ADDRESS: 2140                                                | N Street.                        |
| 18. MEDICA                                                                                                            | AL CERTIFICATION                                                             | 1                                |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:                                                                  |                                                                              | INTERVAL BETWEEN ONSET AND DEATH |
| Immediate cause (a) Herror hage                                                                                       |                                                                              | 7                                |
| Autocodent course(s)                                                                                                  | -, 0                                                                         | of man                           |
| Antecedent cause(s)  Diseases or conditions, if any, (b)  Acceptation                                                 | Rt femoral aslery                                                            | minutes                          |
| giving rise to the above cause DUE TO                                                                                 |                                                                              |                                  |
| stating underlying cause last (c) Alaha wowy                                                                          | RI Telleas region                                                            |                                  |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. |                                                                              |                                  |
| 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:                                                              |                                                                              | 20. AUTOPSY?                     |
| 21a. EXTERNAL CAUSE WAS   21b. PLACE (Home, farm, factory,                                                            | (County)                                                                     | Yes No [                         |
| PRIMARY or CONTRIBUTING OF street, office bldg etc.                                                                   |                                                                              | m.el                             |
| 21d. TIME (Month) (Day) (Year) (Hour)   21e. INJURY OCCURRED                                                          | 21f. HOW DID INJURY OCCUR?                                                   | 11.4                             |
| OF INJURY 5-22.55-2:55 AM. While at work work                                                                         | stabed dwing an o                                                            | roment                           |
| 22. I hereby certify that I took charge of the remains describ                                                        |                                                                              |                                  |
| find that death resulted from: Natural causes [], Accid                                                               | lent 🗌, Suicide 🖺, Homicide 🔁, Undeter                                       | mined cause                      |
| SIGNATURE Trank O Broschart                                                                                           | CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM. | J-22-5J                          |
| 23. BURIAL, CREMATION, SATE THEREOF NAME OF CEMETER                                                                   | Y OR CREMATORY LOCATION (City, town, or co                                   | (State)                          |
| DATE REC'D BY LOCAL REGISTRAN'S SIGNATURE                                                                             | 26. FUNERAL DIRECTOR                                                         | ADDRESS                          |
| 5/25/55 Lawell H. Freglers                                                                                            | Token Li monder. The                                                         | melly                            |
|                                                                                                                       |                                                                              | d                                |

PLEASE WRITE PLAINIX, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important, Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 22. I hereby certify that I attended the deceased from A. ल M, from the causes and on the date stated above. and that death occurred at alive on DATE SIGNED ADDRESS SIGNATURE NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) 23. BURIAL, CREMATION, DATE THEREOF REMOVAL (SPECIFY) Burtonsville. Maryland Union Cemetery FUNERAL DIRECTOR DATE REC'D BY LOCAL

DECEIVED NAM 26 1955

BUREAU V. S.

MARGIN RESERVED FOR BINDING

# CERTIFICATE OF DEATH

Reg. Dist. No.

| 1. PLACE OF DEATH- COUNTY Montgomery MARYLAND                                                                                                                                                                                                                                                                                       | 2. USUAL RESIDENCE (HOME) OF DECEASED COUNTY Montgomery                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CITY (If outside corporate limits, write RURAL and CITY (If outside corporate limits, write RURAL and CITY (If outside corporate limits, write RURAL and LENGTH OF STAY 50 TOWN Since 1/55                                                                                                                                          | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring 56                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| HOSPITAL OR 90 STREET ADDRESS Boswell Nursing Home                                                                                                                                                                                                                                                                                  | STREET (If rural, give location) ADDRESS 9110 Wire Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 3. NAME OF (First) (Middle)  DECEASED (Type or Print) ELIZABETH JANE TIBBETS                                                                                                                                                                                                                                                        | (Last) 4. DATE (Month) (Day) (Year) OF May 1 19 55                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 5. SEX TE 6. COLOR OR RACE 7. SINGLE MARRIED, WIDOWED DIVORCED, (Specify)                                                                                                                                                                                                                                                           | 8. DATE OF BIRTH 9. AGE last birthday   If under. 1 year   If under 24 hrs.   Months.   Days   Hours   Min.   William   Min.   M |
| 10a. USUAL OCCUPATION (Give kiod of work done during most of working life, even if retired)  HOMEMAKET  Own Home                                                                                                                                                                                                                    | Plymouth, Pa. II. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Robert S. Young                                                                                                                                                                                                                                                                                                                     | 14. MOTHER'S MAIDEN NAME<br>Elizabeth J. Hall                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of NO. NO.                                                                                                                                                                                                                            | Nrs. Ellis W. Carnell, 9110 Wire Ave., S. S.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| I. DISEASES OR CONDITIONS DIRECTLY CEADING TO DEATH  Immediate cause  Antecedent cause(s)  Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last  (c)  II. OTHER SIGNIFICANT CONDITIONS  Conditions contributing to the death but not related to the disease or condition causing death. | Condrac disease souryears                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION                                                                                                                                                                                                                                                                             | 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 21. ACCIDENT (Specify) SUICIDE HOMICIDE HOMICIDE  PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY                                                                                                                                                                                                                 | (CITY OR TOWN) (COUNTY) (STATE)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| TIME (Month) (Day) (Year) (Hour)   INJURY OCCURRED While at Not While INJURY m.   Work   At work                                                                                                                                                                                                                                    | HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| SIGNATURE - C. Chegree of title)                                                                                                                                                                                                                                                                                                    | 24 FUNERAL DARECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| REG. 3 1.5.5 the seal total                                                                                                                                                                                                                                                                                                         | Marmor, Co. Jumber 11 Silver Spring, Md                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

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| 6)                                                                                     | MARYLAND STATE DEPARTM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | MENT OF HEALTH—BALTIMORE, 18                     | 04866                         |  |  |  |
|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------|--|--|--|
| y. Th                                                                                  | 4775 CERTIFICA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TE OF DEATH Reg. Di                              | st. No. 223                   |  |  |  |
| ully.                                                                                  | 1. PLACE OF DEATH:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 2. USUAL RESIDENCE (HOME) OF DECEAS              | ED:                           |  |  |  |
| Supply every item of information carefully te the causes of death clearly and legibly. | COUNTY Mont gomery MARYLAND  CITY (If outside cornerate limits write RURAL OR and give nearest town)  TOWN Takoma Park  HOSPITAL OR INSTITUTION OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | TOWN /                                           | and give nearest town 16-15-2 |  |  |  |
|                                                                                        | 75 STREET ADDRESS Washington San nd Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 5404 20 - ave.                                   |                               |  |  |  |
|                                                                                        | 3. NAME OF ALVIDA (Middle) DECEASED: (Type or Print) (Allie) Wood row                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (Last) 4. DATE (Month) OF DEATH: May             | (Day) (Yesr) 2/ 1955          |  |  |  |
|                                                                                        | 5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, RACE: WIDOWED, DIVORCED,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | DATE OF BIRTH: 9. AGE last birthday Months wish  |                               |  |  |  |
|                                                                                        | 10A. USUAL OCCUPATION (Give kind of work done during most of working life. OR INDUSTRY:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | SS 11. BIRTHPLACE (State or foreign country): 11 | 2. CITIZEN OF WHAT            |  |  |  |
|                                                                                        | 13. FATHER'S NAME:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME:                        | aner.                         |  |  |  |
| . "                                                                                    | (Yes, (no) or unk.) (If Yes, give war or dates                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                  |                               |  |  |  |
| TH UNFADING INK<br>Physicians: please w                                                | of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | hospital chart                                   |                               |  |  |  |
|                                                                                        | I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  HAD A  IMMEDIATE CAUSE  (A) RUPTU  DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | re of Interventricular Se                        | ONSET AND DEATH               |  |  |  |
|                                                                                        | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | cardial Infaction                                | **                            |  |  |  |
| WITH<br>it. Phy                                                                        | (c) Cor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | onary Occlusion                                  |                               |  |  |  |
| VLY,                                                                                   | TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | nongry Atelectasis.                              |                               |  |  |  |
| PLAINLY                                                                                | 19a. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ATION 7                                          | 20. AUTOPSY?                  |  |  |  |
| WRITE Hespeciall                                                                       | 21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, factory. OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., etc. INJURY OCCUR? (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                  |                               |  |  |  |
| 770                                                                                    | OF INJURY  OF INJURY  OF INJURY  OR INJURY   | le 🔲                                             |                               |  |  |  |
| TYPE OF                                                                                | 22. I hereby certify that I attended the deceased from alive on SIGNATURE (1915), 1915, and that death occurred the signature of the signature | ed at 19:00 M, from the causes and on the dat    |                               |  |  |  |
| LEASE                                                                                  | 23. BURIAL CREMATION DATE THEREOF NAME OF C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | EMETERY OF CREMATERY ELECATION (Cits, town,      | or county) (State             |  |  |  |
| 14                                                                                     | REGISTRAR May 21-58 F. William Dodes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 2 Warner E. Lumphrey L.                          | Local pring M                 |  |  |  |

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### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH Reg. Dist. No. I. PLACE OF DEATH: 2. USUAL RESIDENCE (HOME) OF DECEASED Montgomery Virginia county Arlington MARYLAND CITYIIf outside corporate limits, write RURAL and give nearest town) CITY (If outside corporate limits, write RURAL) LENGTH OF STAY and give nearest town) (in this place) OR Arlington TOWN Silver Spring vears HOSPITAL OR STREET (If rural give location) INSTITUTION OR **ADDRESS** STREET ADDRESS Boswell Nursing Home 3719 - 25th Rd., North (First) (Last) 4. DATE (Month) (Day) (Year) PAREPA TRACEY (Type or Print) 6. COLOR OR 17. 8. DATE OF BIRTH SINGLE, MARRIED 9. AGE last birthday WIDOWED, DIVORCED, RACE: Days (Specify): widowed 22, 1874 Jan. 10A. USUAL OCCUPATION (Give kind of 108. KIND OF BUSINESS 11. BIRTHPLACE (State or foreign country): |12. CITIZEN OF WHAT work done during most of working life. even if retired: retired OR INDUSTRY: COUNTRY? Housewife Ripley, Ohio U. S. A. 14. MOTHER'S MAIDEN NAME: 13. FATHER'S NAME: Charles Galbreath Eliza Isabell Gaddis IS. WAS DECEASED EVER IN U.S. ARMED FORCES! 17. INFORMANT & ADDRESS (Yes, no, or unk.) (If Yes, give war or dates John C. Tracey, Arlington, Va. of service! None 18. MEDICAL CERTIFICATION INTERVAL BETWEEN DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH ONSET AND CEATH IMMEDIATE CAUSE ANTECEDENT CAUSE (S' DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) 198. MAJOR FINDINGS OF OPERATIO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 19A. DATE OF OPERATION:

(State)

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21D. TIME (Month) (Day) (Year) (Hour)

OF INJURY

21E INJURY OCCURRED While Not while at work

218. PLACE (Home, farm, factory.)

OF INJURY street, office bldg., etc. INJURY OCCUR?

21F. HOW DID INJURY OCCUR?

21c. WHERE DID (City or town)

22. I hereby certify that I attended the deceased from 2-5, 19 to 3-27, 19 5 that I last saw the deceased

alive on 5-26, 1955 and that death occurred at 5-7 M, from the causes and on the date stated above. DATE SIGNED

SIGNATURE BURIAL, CREMATION THEREOF

NAME OF CEMETERY OR CREMATORY CATION City, town, or county)

Shipment & burial Elmwood Cemetery

Kansas City, Missouri

(County)

Silver Spring.

Soul & NOT

BUREAU V. S.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   | 04  | 838   |
|---|-----|-------|
|   | Keg | Dist? |
| - | No  | 217   |

| I. PLACE OF DEATH:                                                                                                                         | 2. USUAL RESIDENCE (HOME) OF DECEASED:                         |                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------|
| COUNTY Montgomery MARYLAND                                                                                                                 | STATE Maryland COUNTY Montgo                                   | omery                               |
| CITY (If outside corporate limits, write RURAL   LENGTH OF STAY                                                                            | CITY (If outside corporate limits write RURAL and g            | give nearest town)                  |
| OR and give nearest town) (in this place) (TOWN Silver Spring 5 yrs                                                                        | TOWN Silver Spring                                             | 56                                  |
| HOSPITAL OR INSTITUTION OR GOOD Development                                                                                                | STREET (If rural, give location)                               | 1                                   |
| STREET ADDRESS 123 Boundary Ave.                                                                                                           | ADDRESS 723 Boundary Ave.                                      |                                     |
| 3. NAME OF (First) (Middle) DECEASED: (Type or Print) Flle mas Uslie                                                                       | (Last) 4. DATE (Month) (Day) OF DEATH May 3                    | (Year)                              |
| 5. SEX:   6. COLOR OR   7. SINGLE, MARRIED.   8. DATE                                                                                      |                                                                | AR IF UNDER 24 HRS.                 |
| Female White Widowed Divorced 3/4/                                                                                                         | 06 49 yrs. Months Day                                          | Hours Min.                          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife Own home                               |                                                                | COUNTRY?                            |
| 13. FATHER'S NAME:                                                                                                                         | 14. MOTHER'S MAIDEN NAME:                                      |                                     |
| Harry W. Ensor                                                                                                                             | Edna Moore                                                     |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY No.: (Yes, no, or unk.) (If Yes, give war or datea of service) 69-052-0017 | 17. INFORMANT & ADDRESS:<br>r. Pedro G. Villalon, 723 Boundary |                                     |
| 18. MEDICA                                                                                                                                 | Silver Sprin                                                   | 0,                                  |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:                                                                                       |                                                                | INTERVAL BETWEEN<br>ONSET AND DEATH |
| Immediate cause (a) Henry hage                                                                                                             | due to facuationis?                                            | France of and                       |
| Immediate cause (a) DUE TO                                                                                                                 | To Mariano                                                     | on kets.                            |
| Antecedent cause(s)                                                                                                                        |                                                                | Hore:                               |
| Diseases or conditiona, if any, (b)                                                                                                        |                                                                | <i>I</i>                            |
| giving rise to the above cause DUE TO stating underlying cause last                                                                        |                                                                |                                     |
| IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING                                                                                               |                                                                |                                     |
| TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                                                                    |                                                                |                                     |
| 19a. DATE OF OPERATION:   19b. MAJOR FINDING OF OPERATION:                                                                                 |                                                                | 20. AUTOPSY?                        |
| 0                                                                                                                                          |                                                                | Yes No                              |
| 21s. EXTERNAL CAUSE WAS PRIMARY  or CONTRIBUTING  OF street, office bldg., etc. CAUSE OF DEATH.                                            | 2ic. (City or town) (County)                                   | (State)                             |
| 21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED While at Not while INJURY M.                                                    | 21f. HOW DID INJURY OCCUR?                                     |                                     |
| 22. I hereby certify that I took charge of the remains describ                                                                             | ped above, held an Autopsy   Inspection  .                     | Inquiry [a], and                    |
| find that death resulted from: Natural causes [], Accid                                                                                    |                                                                |                                     |
| SIGNATURE                                                                                                                                  | CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER                 | DATE SIGNED                         |
| Trank J. Broschart                                                                                                                         | M. D. ASSISTANT MEDICAL EXAM.                                  | 5-3-55                              |
| Burial CREMATION DATE THEREOF NAME OF CEMETER Ft. Lincoln C                                                                                |                                                                |                                     |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE) REG - 4 55 Thances (Alter                                                                       | 24. FUNERAL DIRECTOR 8434 Ga. Ave                              |                                     |
|                                                                                                                                            | 7. Silver Sprin                                                | g, Maryland                         |

MEDICAL EXAMINER'S CHETTER ATE OF DEATH

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### CERTIFICATE OF DEATH Reg. Dist. No. 215

| 20 # 0                                                                                              | OBMITTORIA                          | d of Billetin Reg. Dist.                                                   |                        |
|-----------------------------------------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------------------|------------------------|
| 1. PLACE OF DEATH:                                                                                  |                                     | 2. USUAL RESIDENCE (HOME) OF DECEASED                                      | ):                     |
| COUNTY Montgomery                                                                                   | MARYLAND                            | STATE Virginia COUNTY                                                      |                        |
| CITY (If outside corporate llmits, write R<br>OR and give nearest town)                             | URAL LENGTH OF STAY (in this place) | CITY(If outside corporate limits, write RURAL a<br>OR<br>TOWN Alexandria   | nd give nearest town)  |
| HOSPITAL OR                                                                                         | 1 2 00,7                            | STREET (If rural give location)                                            | 1                      |
| SINSTITUTION OR STREET ADDRESS. S. Naval Hos                                                        | pital                               | ADDRESS<br>Presidential Gardens A                                          | pt A-3 √               |
| 3. NAME OF (First) DECEASED: (Type or Print) Baby                                                   |                                     | (Last) 4. DATE (Month) (I<br>WALSH OF DEATH: May                           | Ohy) (Year)<br>9 19 55 |
| 5. SEX: 6. COLOR OR 7. SINGLE, WIDOWE (Specify):                                                    | D. DIVORCED.                        | OF BIRTH: 9. AGE last birthday Months D                                    | ays Hours Min.         |
|                                                                                                     | None                                | 11. BIRTHPLACE (State or foreign country):  12.                            |                        |
| 13. FATHER'S NAME:                                                                                  |                                     | 14. MOTHER'S MAIDEN NAME:                                                  | 0.0                    |
| Michael J. WALSH                                                                                    |                                     | Mildred A. CAMPBELL                                                        |                        |
| Yes, no, or unk.) (If Yes, give war or dates of service)                                            | 16. SOCIAL SECURITY NO.             | Father Michael J. WALSH                                                    |                        |
|                                                                                                     | 8. MEDICAL CERTIFICAT               | Same as above                                                              |                        |
| I DISEASES OR CONDITIONS DIRECTLY                                                                   | LEADING TO DEATH                    | wity at 27 gestation                                                       | ONSET AND DEATH        |
| IMMEDIATE CAUSE  ANTECEDENT CAUSE (S)                                                               | DUE TO                              | 0                                                                          | - VIII                 |
| DISEASES OR CONDITIONS, IF ANY,                                                                     | (B)                                 |                                                                            |                        |
| GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.                                       | DUE TO                              |                                                                            |                        |
| II OTHER SIGNIFICANT CONDITIONS CO                                                                  | (C)<br>NTRIBUTING                   |                                                                            |                        |
| TO THE DEATH BUT NOT RELATED TO                                                                     | THE                                 |                                                                            |                        |
| DISEASE OR CONDITION CAUSING DE                                                                     | FINDINGS OF OPERATION               | N                                                                          | LOO AUTORION           |
| 2                                                                                                   |                                     |                                                                            | YES NO                 |
| 21A. ACCIDENT WAS UNDERLYING 21IOR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |                                     | tory, 21c, WHERE DID (City or town) (Count etc. INJURY OCCUR?              | ty) (State)            |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.                                                  | While Not while at work             | 21F. HOW DID INJURY OCCUR?                                                 |                        |
| 22. I hereby certify that I attended the                                                            | e deceased from 9 Ma                | y, 1955, to 9 May , 1955, that I last                                      | saw the deceased       |
| alive on .9 May , 1955, and                                                                         |                                     | 8:20PM, from the causes and on the date                                    |                        |
| W. S. MATTHEWS LCDR MC USN                                                                          | U. S. Naval How                     | notal NNMC Bethesda, Maryland                                              |                        |
| 23. BURIAL, CREMATION, DATE THEREO REMOVAL (SPECIFY) Complete Cremation 14 May                      |                                     | err or crematory Location (City, town, or corge Co Crematory Prince George |                        |
| DATE REC'D BY LOCAL REGISTRAR'S REGISTRAR 13 May 1955  May 1955                                     |                                     | R. A. Pumphrey Funeral Home                                                | ADDRESS                |
| - Jany - John I Jany                                                                                | c and                               | / 7557 Wisconsin Avenue, Bether                                            | HEL, Mela              |

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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| CERT                                                                                                                                   | FICAT                                 | E OF DEA                                     | TH                     | Reg. Dist.     | No. 2              | 16         |
|----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------------------------|------------------------|----------------|--------------------|------------|
| 1. PLACE OF DEATH:                                                                                                                     |                                       | 2. USUAL RESID                               | ENCE (HOME) OF         | DECEASED       | :                  |            |
| COUNTY Montgomery MARY                                                                                                                 | LAND                                  | STATE Virginia COUNTY Roanoke                |                        |                |                    |            |
| CITY (If outside corporate limits, write RURAL LEN                                                                                     | IGTH OF STAY                          |                                              | corporate limits, writ |                |                    | est town   |
| Town Bethesda                                                                                                                          | in this place)                        | TOWN Roan                                    |                        |                | 83x                | 1-3        |
| HOSPITAL OR The Clinical Center STREET ADDRESS National Institutes                                                                     | of Health                             | STREET<br>ADDRESS<br>1211                    | (If rural gi           | ve location)   |                    | /          |
| 3. NAME OF (First) (Middle)                                                                                                            |                                       | (Last)                                       | 4. DATE (Mo            | nth) (D        | ay) (Y             | ear)       |
| DECEASED:<br>(Type or Print) Lelia Dew                                                                                                 | Me                                    | ebb                                          | OF<br>DEATH: M.        | av             | 8 19               | 55         |
| 5. SEX:   6. COLOR OR   7. SINGLE, MARRIED,                                                                                            | 8. DATE                               |                                              | 9. AGE last birthday   | IF UNDER 1 Y   |                    |            |
| F WIDOWED DIVORCE (Specify) Married                                                                                                    | Novemb                                | er 10, 1897                                  | 57 yrs.                | 5   2          | ys Hours           | Min.       |
| OA. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired): Housewife                                  |                                       | Virginia                                     | (State or foreign cour |                | CITIZEN OF         | WHAT       |
| IS, FATHER'S NAME:                                                                                                                     |                                       | 14. MOTHER'S M                               | AIDEN NAME:            | 1 0            |                    |            |
| Charles A. Shaner                                                                                                                      |                                       | Lelia P.                                     | Hyman                  |                |                    |            |
| S. WAS DECEASED EVER IN U.S. ARMED FORCEST 16. SOCIAL                                                                                  | SECURITY NO.                          | 17. INFORMANT                                |                        |                |                    |            |
| (Yes, no, or unk.) (If Yes, give war or dates Not ava                                                                                  | ilable                                | The medical                                  | record, The            | Clinica        | l Cente            | er         |
|                                                                                                                                        | L CERTIFICA                           | rion                                         |                        |                | INTERVAL           | BETWEE     |
| ANTECEDENT CAUSE (S)  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST  DUE TO  21  DUE TO |                                       | emprrhage<br>cenal hyperter<br>Pulmonary Fil |                        | -              |                    |            |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTIN TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                    | G                                     |                                              |                        |                |                    |            |
| 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS                                                                                            |                                       | N                                            |                        |                | 20. AUT            | OBEVI      |
| 0 2 0                                                                                                                                  |                                       |                                              |                        |                | YES Y              | NO 🗌       |
| 21A. ACCIDENT WAS UNDERLYING 21B. PLACE (IDEN CONTRIBUTING CAUSE OF DEATH OF INJURY STREET, NOTIFY MEDICAL EXAMINER)                   | Home, farm, fac<br>reet, office bldg. | etc. 21c. WHERE INJURY OCCU                  | DID (Clty or town)     | (County        | (S                 | tate)      |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E INJUI<br>OF INJURY M. at work                                                                | Not while at work                     | 21F. HOW DID                                 | INJURY OCCUR?          |                |                    |            |
| 22. I hereby certify that I attended the deceased                                                                                      |                                       |                                              |                        |                |                    |            |
| alive on May 8, 1955, and that death SIGNATURE                                                                                         |                                       | The Clinian D. National                      | S Conton               | the date s DAT | tated above signed | re.<br>155 |
| REMOVAL (SPECIFY) 5-0-55                                                                                                               |                                       | ERY OR CREMATORY                             | LOCATION (CI           | ty, town, or   | county /           | (State     |
| DATE REC'D BY LOCAL   REGISTRAR'S SIGNATUR                                                                                             | noke                                  | DUNERAL                                      | Roanoke,               |                | ADDRESS            |            |
| REGISTRAR 5/9/55 Bessie M. Hos                                                                                                         | nkron                                 | 118000 4                                     | Runfers                | Bethe          | esda, Mo           | 1.         |

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

| 4873 CERTIFICAT                                                                                                                      | TE OF DEATH Reg. Dist.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | No. 215                    |
|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|
| 1. PLACE OF DEATH:                                                                                                                   | 2. USUAL RESIDENCE (HOME) OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ):                         |
| Wont comount                                                                                                                         | Windship Andi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | an androne                 |
| COUNTY MONTGOMERY MARYLAND  CITY (If outside corporate limits, write RURAL) LENGTH OF ST                                             | STATE VIRGINIA COUNTY ARII  AY CITY(If outside corporate limits, write RURAL a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | nd give nearest town       |
| OR and give nearest town) (in this place)  X TOWN Bethesda Rural 2 days                                                              | or<br>Town Arlington                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 83 × -3                    |
| HOSPITAL OR SINSTITUTION OR STREET ADDRESSU. S. Naval Hospital                                                                       | STREET (If rural give location) ADDRESS 3412 North Vermond Str                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | eet /                      |
| 3. NAME OF (First) (Middle)                                                                                                          | (Last)   4. DATE (Month) (I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Day) (Year)                |
| OECEASED: (Type or Print) Jonathon Joseph                                                                                            | WEST OF DEATH: MAY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 11 19 55                   |
| 5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DA RACE: WIDOWED, DIVORCED,                                                               | TE OF BIRTH: 9. AGE last birthday IF UNDER 1 Y                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                            |
| IOA. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):  None  None                             | 11. BIRTHPLACE (State or foreign country):  12.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CITIZEN OF WHAT            |
| 13. FATHER'S NAME:                                                                                                                   | 14. MOTHER'S MAIDEN NAME:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                            |
| Gordon H. WEST                                                                                                                       | Lucille C. O'SWLLIVAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                            |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCEST   16. SOCIAL SECURITY NO.                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            |
| (Yes, no, or unk.) (If Yes, give war or dates of service)                                                                            | Father LTCOL Gordon H. WEST Same as above                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                            |
| DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  DUE TO  DUE TO  DUE TO  DUE TO | aturity                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 8 Ars 2 days               |
| (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            |
| TO THE DEATH BUT NOT RELATED TO THE                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            |
| DISEASE OR CONDITION CAUSING DEATH.  19a. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERAT                                           | TION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 20. AUTOPSY?               |
| 2                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | YES K NO                   |
| 21A. ACCIDENT WAS UNDERLYING   21B. PLACE (Home, farm, OR CONTRIBUTING   CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (State)                    |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCUR<br>OF INJURY M. 21E INJURY OCCUR<br>While Not while<br>at work                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            |
| 22. I hereby certify that I attended the deceased from 9                                                                             | May , 19 55to 11 May , 19 55, that I last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | saw the deceased           |
| SIGNATURE // CALIFIA                                                                                                                 | at 5:20 NPM from the causes and on the date an | stated above.<br>re signed |
| 23. BURIAL, CREMATION, DATE THEREOF NAME OF CEM                                                                                      | n National Cemetery Arlington, Vi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                            |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR 12 May 1955  Page 15 April 1999                                                  | R4. FUNERAL DIRECTOR HUME<br>7557 Wisconsin Avenue, Bethes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                            |

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# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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| 4012                                                                                                                | CERTIFICATI                                                                    | E OF DEA         | ATH                                | Reg. I                       | Dist. No. 216                              |
|---------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------|------------------------------------|------------------------------|--------------------------------------------|
| 1. PLACE OF DEATH:                                                                                                  |                                                                                | 2. USUAL RESID   | ENCE (HOME)                        |                              |                                            |
| COUNTY Montgomery CITY (If outside corporate limits, wri OR and give nearest town)  TOWN Bothoods                   | MARYLAND te RURAL LENGTH OF STAY (in this place)                               | CITY (If outsi   |                                    | Coits, write RURA            | OUNTY Mont com.<br>L and give nearest town |
| HOSPITAL OR                                                                                                         | gin Lane                                                                       | STREET           | <u>ethesda</u><br>607 Elgi         | f rural give loca<br>In Lane | tion) X                                    |
| 3. NAME OF (First) DECEASED: (Type or Print) Sarah                                                                  |                                                                                | ·(Last)<br>irlow | 4. DATE<br>OF<br>DEATH:            | May                          | (Day) (Year)                               |
| Female White Spe                                                                                                    | owed, divorced, edity): Widowed Apr                                            | of BIRTH: 9 1871 | 84                                 | yrs. Months                  | 2                                          |
| IOm. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):  HOU SEW II            | 10b. KIND OF BUSINESS OF INDUSTRY:                                             |                  | , Englar                           |                              | 12. CITIZEN OF WHA COUNTRY? United Sta     |
| Samuel Blow                                                                                                         |                                                                                |                  | arnswort                           | h                            |                                            |
| stating the underlying cause last. DU                                                                               | None  18. MEDICAL CERTIFICATE LEY LEADING TO DEATH (a) Cardiac 7 (b) Mypertens | O.F.Smith        | -6607 El                           |                              | Interval Betwee                            |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death bur related to the disease or condition causi | ng death.                                                                      |                  |                                    |                              | 20. AUTOPSY                                |
| 30 march 1955 Fraction                                                                                              | or findings of operation                                                       | st Femu          | 2                                  |                              | Yes No No                                  |
| 21. ACCIDENT (Specify) PL<br>SUICIDE OF                                                                             | ACE (Home, farm, factory, street                                               | (CITY OR TO      | VN)                                | (COUNTY)                     | (STATE)                                    |
| TIME (Month) (Day) (Year) (Hour) OF INJURY m.                                                                       | INJURY OCCURED While at Not While Work □ At Work □                             | HOW DID INJUI    |                                    |                              |                                            |
| SIGNATURE  SACK W SANIES  23 BURIAL, CREMATION, DATE THE REMOVAL (Specify)  RUNTING THE REMOVAL (Specify)           | d that death occurred at (Degree or title)  REOF NAME OF CEMETE  155 Parkla    | :00 AM , fro     | m the causes DDRESS VILL Y LOCATIO | and on the d                 | ate stated above.  DATE SIGNED  Play 1955  |
| DATE REC'D BY LOCAL REGISTRA                                                                                        | R'S SIGNATURE                                                                  | PALL OF          | ECTOR                              | 0                            | thesda, Md.                                |

VS. A15

MARGIN RESERVED FOR BINDING



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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

| ERTIFIC | ATE | OF | DE | HT |
|---------|-----|----|----|----|

| 4010                                                                                 | CERTIFIC                 | ATE OF             | DEATH                          | Reg.                      | Dist. No. 218                          |
|--------------------------------------------------------------------------------------|--------------------------|--------------------|--------------------------------|---------------------------|----------------------------------------|
| I. PLACE OF DEATH:                                                                   |                          | 2. USUA            | L RESIDENCE (HOM)              | E) OF DECEASE             | D:                                     |
| COUNTY Monte                                                                         | Tr. mart Ass             | 000.00             | bar Luur M                     |                           | COLLEGE MANAGE                         |
| CITY (If outside corporate limits, wri                                               | MARYLAN                  | STATI              | Maryland (If outside corporate |                           | COUNTY Montg AL and give nearest town) |
| OR and give nearest town)                                                            | (in this p               | lace) OR TOWN      |                                |                           | \ \                                    |
| HOSPITAL OR                                                                          | Rural 55MO               | STREE              | darthersi                      | Urg<br>(If rural give loc | ation                                  |
| INSTITUTION OR<br>STREET ADDRESS                                                     |                          | ADDR               |                                |                           | acton)                                 |
| SIREEI ADDRESS                                                                       |                          |                    | Rural.                         | Md,                       |                                        |
| 3. NAME OF (First)                                                                   | (Middle)                 | (Last)             | 4. DATE                        | (Month)                   | (Day) (Year)                           |
| (Type or Print) William                                                              | Eugene                   | Wilkerso           | n DEATH                        | : May                     | 18 19 55                               |
| 5. SEX: S. COLOR OR 7. SIN                                                           | GLE, MARRIED, 8.         | DATE OF BIRTH      |                                |                           | ER 1 YEAR IF UNDER 24 HRS.             |
| Male White (sp                                                                       | DOWED, DEVENCED,         | Nov 30-19          | 54                             | yrs. Month                | Bays Hours Min.                        |
| 10a. USUAL OCCUPATION Give kind of                                                   | 10b. KIND OF BUSIN       | NESS OR   II. BIRT | THPLACE (State or fo           | oreign country):          | 12. CITIZEN OF WHAT COUNTRY?           |
| work done during most of working life, even if retired): LnIant                      | INDUSTRI:                | G                  | aithersburg                    | r. Md                     | USA                                    |
| 13. FATHER'S NAME:                                                                   | 1                        |                    | ER'S MAIDEN NAME               |                           |                                        |
| Hugh W. Wilkerson                                                                    |                          | Ne                 | ncy L. Sel                     | hv                        |                                        |
| 15 WAS DECEASED EVER IN ILS ARMED FORCE                                              | S? 16. SOCIAL SECURITY N |                    | NT & ADDRESS:                  | 3                         |                                        |
| Yes, no, or unk.) (If Yes, give war or dates service)                                | of                       |                    | Wilkerson                      | Geither                   | aghung Md                              |
|                                                                                      |                          |                    | #TTVOI 2011                    | Gar Ullo                  | spare, ma,                             |
| I DIGELORG OF CONDUCTIONS STREET                                                     | 18. MEDICAL CERT         |                    |                                |                           | Interval Between                       |
| I. DISEASES OR CONDITIONS DIRECT                                                     | LY LEADING TO DEAT       | of a               | 1                              | 1 -1                      | Onset And Deatl                        |
| Immediate cause                                                                      | (a) asura                | hon so             | sur ce                         | ulento                    | 1 Tour                                 |
| DU                                                                                   | E TO                     | 1.100              | stru co                        |                           |                                        |
| Antecedent causes (s) Diseases or conditions, if any,                                | (b) Unles                | stilal             | Meun                           | guess                     | 1 day                                  |
| giving rise to the above cause<br>stating the underlying cause last. DU              | E TO                     |                    |                                |                           |                                        |
|                                                                                      | (c)                      |                    |                                |                           |                                        |
| II. OTHER SIGNIFICANT CONDITIONS                                                     |                          |                    |                                |                           |                                        |
| Conditions contributing to the death bu<br>related to the disease or condition causi |                          | 2                  | me                             |                           |                                        |
| 19a. DATE OF OPERATION:   19b. MAJ                                                   |                          | AT10N              |                                |                           | 20. AUTOPSY ?                          |
|                                                                                      |                          |                    |                                |                           | Yes No                                 |
| 2I. ACCIDENT (Specify) PL<br>SUICIDE OF                                              | ACE (Home, farm, factor  | y, street, (CITY   | OR TOWN)                       | (COUNTY)                  | (STATE)                                |
| HOMICIDE IN.                                                                         | JURY                     |                    |                                |                           |                                        |
| TIME (Month) (Day) (Year) (Hour)                                                     | While at Not Wi          | HOW DI             | D INJURY OCCUR?                |                           |                                        |
| INJURY m.                                                                            | Work At Wo               | rk 🗀               |                                |                           |                                        |
| 22. I hereby certify that I attended                                                 | the deceased from        | 4 /2 1953          | to may 15.                     | 1955, that I              | last saw the deceased                  |
| alive on/my 17, 1955, an                                                             |                          | 1/ 1               |                                |                           |                                        |
| SIGNATURE                                                                            | (Degree or title)        | 2 de               | ADDRESS                        | and on the t              | DATE SIGNED                            |
| Ilman ? , prosto                                                                     | ens MD.                  | Hers               | u serlewn                      | had he                    | can 15, 1955                           |
| 23. BURIAL, CREMATION, DATE THE                                                      | REOF NAME OF C           | EMETERY OR CRE     |                                | ON (City, town,           |                                        |
| REBUYALa (Specify)   5-20-                                                           |                          | Lawn               | Rock                           | ville. N                  | 1d,                                    |
| REGISTRAR                                                                            | R'S SIGNATURE            | 24. FUNEI          | RAL DIRECTOR                   |                           | ADDRESS                                |
| May 19-55 /1/201                                                                     | Nel Than                 | Le Ernes           | t C. Gertn                     | en Goiti                  | nerchure Md                            |

VS. A15

PLEASE WRITE PLAINIX, WITH

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DECEINED.

BUREAU V. S.

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Reg Dist No 2/

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| 5       | every                    |
| BINDING | Supply every item of inf |

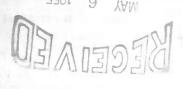
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK.

MARGIN RESERVED FOR BINDING

| CENTIFICAT                                                                                                                       | E OF DEATH Reg. Dist.                                                                        | No                      |
|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------|
| 1. PLACE OF DEATH:                                                                                                               | 2. USUAL RESIDENCE (HOME) OF DECEASED                                                        | );                      |
| county Montgomery Maryland                                                                                                       | STATE COUNTY                                                                                 |                         |
| CITY (If outside corporate limits, write RURAL or and give nearest town)  TOWN  Bethesda  LENGTH OF STAY (in this place) 74 days |                                                                                              | nd give nearest town    |
| HOSPITAL OR The Clinical Center                                                                                                  | STREET (If rural give location)                                                              |                         |
| 50 STREET ADDRESS Natl. Institutes of Health                                                                                     | ADDRESS 255 - 12th St. S.E.                                                                  | <b>√</b>                |
| 3. NAME OF (First) (Middle)                                                                                                      |                                                                                              | Day) (Year)             |
| (Type or Print) Sarah Jane Wi                                                                                                    | lliams OF DEATH: May                                                                         | 3 1955                  |
| 5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE WIDOWED, DIVORCED.                                                               | ember 1, 1888 9. AGE last birthday Funder iv Months D.                                       |                         |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife                           | 11. BIRTHPLACE (State or foreign country):  12.                                              | CITIZEN OF WHATCOUNTRY? |
| 13. FATHER'S NAME:                                                                                                               | 14. MOTHER'S MAIDEN NAME:                                                                    | O.D.R.                  |
| Timetowant Thomas                                                                                                                | Carrala Marialat                                                                             |                         |
| Lieutenant Thompson  18. WAS DECEASED EVER IN U.S. ARMED FORCES!   16. SOCIAL SECURITY NO.                                       | Sarah Wright                                                                                 |                         |
| (Yes, no, or unk.) (If Yes, give war or dates of service) None                                                                   | The medical record, The Clinic                                                               | al Center               |
| 18. MEDICAL CERTIFICA I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                         | TION                                                                                         | INTERVAL BETWEEN        |
| 1717                                                                                                                             | of cervix with post-operative                                                                |                         |
| ANTECEDENT CAUSE (S) DUE TO bowel obstr                                                                                          | uction and peritonitis                                                                       |                         |
| DISEASES OR CONDITIONS, IF ANY. GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  (B)  DUE TO                       |                                                                                              |                         |
| (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING                                                                                 |                                                                                              |                         |
|                                                                                                                                  | ve cardiovascular disease                                                                    |                         |
| 4-25-55 Small bowel obstruction                                                                                                  |                                                                                              | 20. AUTOPSY7            |
| 21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fa OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)      | tetory, 21c. WHERE DID (City or town) (Count INJURY OCCUR?                                   | y) (State)              |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRE While Not while at work at work                                         |                                                                                              |                         |
| 22. I hereby certify that I attended the deceased from Feb                                                                       |                                                                                              |                         |
| alive on May 3, 1955, and that death occurred a SIGNATURE                                                                        | The Clinical Center DAT                                                                      | E SIGNED                |
|                                                                                                                                  | M. D. Natl. Institutes of Health TERY OR CREMATORY   LOCATION (City, town, or Washington, D. |                         |
|                                                                                                                                  | L CA SUNIEDAL DIDECTOR                                                                       |                         |

VS. A15-10-53



correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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|                             | . The                                                                                      |
|-----------------------------|--------------------------------------------------------------------------------------------|
|                             | 2                                                                                          |
| M                           | Careful                                                                                    |
| •                           | information                                                                                |
| 0                           | item of                                                                                    |
| 1G                          | every                                                                                      |
| BINDIN                      | Supply                                                                                     |
| FOR                         | INK.                                                                                       |
| MARGIN RESERVED FOR BINDING | PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information Carefull |
| ARGIN                       | WITH                                                                                       |
| W                           | PLAINLY,                                                                                   |
| 1)                          | WRITE                                                                                      |
|                             | OR                                                                                         |
| 66 - 01                     | TYPE                                                                                       |
| S. A15 — 10 - 55            | PLEASE                                                                                     |

| MARYLAND STATE DEPARTMEN 4877 CERTIFICATI                                                                                                                      |                                                                                    | 04876<br>No. 216                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------|
| 1. PLACE OF DEATH:                                                                                                                                             | 2. USUAL RESIDENCE (HOME) OF DECEASE                                               |                                     |
|                                                                                                                                                                | 47.1                                                                               | ):<br> / 2                          |
| COUNTY MONTGOMERY  CITY (If outside corporate limits, write RURAL OR and give nearest town)  TOWN Bethesda  MARYLAND  LENGTH OF STAY  (in this place)  52 days | STATE Alabama COUNTY CITY(If outside corporate limits, write RURAL a OR TOWN Mulga | nd give nearest town)               |
| HOSPITAL OR The Clinical Center STREET ADDRESS Natl. Institutes of Health                                                                                      | STREET (If rural give location) ADDRESS BOX 225                                    |                                     |
| 3. NAME OF (First) (Middle) DECEASED: (Type or Print) Carol R. W                                                                                               | ilson of DEATH: May 2                                                              | Oay) (Year)<br>O 1955               |
| RACE: WIDOWED, DIVORCED,                                                                                                                                       | vember 1954   yrs. 6                                                               | ays Hours Min.                      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child                                                             | 11. BIRTHPLACE (State or foreign country): 12.  Alabama                            | CITIZEN OF WHAT COUNTRY? U.S.A.     |
| 13. FATHER'S NAME:                                                                                                                                             | 14. MOTHER'S MAIDEN NAME:                                                          |                                     |
| Lloyd Wilson                                                                                                                                                   | Annie Watkins                                                                      |                                     |
| 18. WAS DECEASED EVER IN U.S. ARMED FORCEST (Yes, no, or unk.) (If Yes, give war or dates of service)  NO  NO  NO  NO  NO  NO  NO  NO  NO  N                   | The medical record, The Clinical                                                   | 1 Center                            |
| 18. MEDICAL CERTIFICAT  I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  754.4  IMMEDIATE CAUSE  (A) Postoperative                                          |                                                                                    | INTERVAL BETWEEN<br>ONSET AND DEATH |
| ANTECEDENT CAUSE (S)                                                                                                                                           |                                                                                    |                                     |
|                                                                                                                                                                | y aortic window                                                                    |                                     |
| (c) Interatri                                                                                                                                                  | ial septal defect                                                                  |                                     |
| TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                                                                                        |                                                                                    |                                     |
| 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION                                                                                                       |                                                                                    | 20. AUTOPSY?                        |
| May 19, 1955   Interatrial septal defect;                                                                                                                      |                                                                                    | YES NO                              |
| OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                            |                                                                                    | y) (State)                          |
| OF INJURY OCCURRED  M. 21E INJURY OCCURRED  While Not while at work at work                                                                                    | 21F. HOW DID INJURY OCCUR?                                                         |                                     |
| 22. I hereby certify that I attended the deceased from Mar.                                                                                                    |                                                                                    | saw the deceased                    |
| LLOGE C. Kouser M.D. M                                                                                                                                         | The Clinical Center  D. Natl Institutes of Health                                  | E SIGNED                            |
| 28. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETE  REMOVAL (SPECIFY) 5-2/-55                                                                                  | ERY OR CREMATORY LOCATION, (City town, or                                          | alabuma                             |
| DATE REC'D BY LOCAL   REGISTRAR'S SIGNATURE REGISTRAR 5/23/155 Beasie M. Chompson                                                                              | The S. N. Thire Co 290/-                                                           | ADDRESS 14 st WED                   |

DECEIVED NAY SE 1955

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

VS. A15 -- 10 - 53

|          | . I                    | 4873                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | CERTIFICAT              | E OF DEATH                   | Reg. Dist.                    | No. 216             |
|----------|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------|-------------------------------|---------------------|
|          | carefully<br>legibly.  | I. PLACE OF DEATH:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 2. USUAL RESIDENCE           | HOME) OF DECEASED             | _                   |
|          | re<br>gi               | COUNTY / oulgome                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | MARYLAND                | STATE / Plerylan             | COUNTY MIM                    | Momens.             |
| 1        |                        | CITY (If outside corporate limits, write OR and give nearest town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | OR CITY(If outside corporate | e limits, write RURAL an      | d eve nearest town) |
| M)       | information            | HOSPITAL OR INSTITUTION OR STREET ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Gustin                  | STREET ADDRESS 8920          | (If rural give location)      | Pourt'              |
|          | of<br>ath              | 3. NAME OF (First) DECEASED: (Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Middley (Middle)        | Wood                         | DATE (Month) (De OF DEATH May | (Year) (955         |
|          | ite                    | Male prite Specia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Misgrala!               | 10, 1885 7                   | O yrs. Months Da              | ya Hours Min.       |
| NG       | y every                | NOA. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): M, O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | OR INDUSTRY:            | 11. BIRTHPLACE (State or     | foreign country):  12. C      | OUNTRY              |
| BINDING  | Supply<br>ite the c    | 13. FATHER'S NAME:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | . Wood                  | 14. MOTHER'S MAIDEN I        | f. That                       | e                   |
| FOR I    | INK.                   | (Yes. po, or upt.) (If Yes, give war or date of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         | 8920 Halvin                  | coul A. Wo                    | od                  |
|          |                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 18. MEDICAL CERTIFICA   | TION                         |                               | INTERVAL BETWEEN    |
| 回        | ZZ                     | I DISEASES OR CONDITIONS DIRECTL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Y LEADING TO DEATH      |                              |                               | ONSET AND DEATH     |
| RESERVED | FADING<br>ins: plea    | IMMEDIATE CAUSE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (A) E GA                | uslin,                       | \                             |                     |
| RES      | UN                     | ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (B) ALP LL              | ou alosi - hue               | Hellowed)                     | 4 years             |
| MARGIN   | H                      | GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | DUE TO COUNTY           | D. O.                        | Charles A.                    | 44000               |
| MAI      | 28                     | II OTHER SIGNIFICANT CONDITIONS TO THE DEATH BUT NOT RELATED T DISEASE OR CONDITION CAUSING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | CONTRIBUTING            | we come                      | Turad                         | 1100                |
|          | Z                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | R FINDINGS OF OPERATIO  | ON .                         |                               | 20. AUTOPSY3        |
|          | 7                      | -2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | -                       |                              |                               | YES NO              |
|          | WRITE PI<br>especially | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         | ., etc. INJURY OCCUR?        |                               | (State)             |
|          | P 700                  | 21D. TIME (Month) (Day) (Year) (Hour) OF "INJURY M.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | While Not while at work | D 21F. HOW DID INJURY        | OCCUR?                        |                     |
|          | OI                     | 22. I hereby certify that I attended                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 4650                         | , 19.5 Sthat I last           |                     |
|          | TYP                    | alive on SX 8 3 10 SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | A. D. 150 Que                | Was World                     | S SIGNED            |
|          | PLEASE                 | 23. BURIAL, CREMATION, DATE THE BEMOVAL (SPECIFY) 5/20/5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | SEOF NAME OF CEME       | lucks Century 1              | ashing tow                    | county) (State)     |
| 2        | PL                     | DATE REC'D BY LOCAL REGISTRAL REGISTRAR 5/19/55 Bessie                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | M. Shornfalon           | 24 FUNERAL BIRECTO           | 2901144                       | et. W.W. Og         |
|          |                        | A DATE OF THE PARTY OF THE PART |                         |                              |                               |                     |

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| 4013                                                                                                                                   | T OH DHA                                |                                 | 0 20 0                            |
|----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|---------------------------------|-----------------------------------|
| Item 9, FilmGl81 5-17-55 etCERTIFICATI                                                                                                 | E OF DEA                                | I'H Reg. Di                     | st. No                            |
| 1. PLACE OF DEATH:                                                                                                                     | 2. USUAL RESID                          | ENCE (HOME) OF DECEAS           | ED:                               |
| COUNTY MONTGOMOTY MARYLAND                                                                                                             | STATE MAY                               | vland COUNTY Mon                | t.comerw                          |
| CITY (If outside corporate limits, write RURAL LENGTH OF STAY                                                                          | CITY(If outside                         | corporate limits, write RURAL   |                                   |
| X TOWN Bethesda - Rural 10 Mos. 2 day                                                                                                  | OR<br>TOWN                              | Silver Spring                   | 56                                |
| HOSPITAL OR                                                                                                                            | STREET                                  | (If rural give location         | n) /                              |
| INSTITUTION OR                                                                                                                         | ADDRESS                                 | bhowston Dudwo                  |                                   |
| 3. NAME OF (First) (Middle)                                                                                                            | (Last)                                  | thhampton Drive                 | (Day) (Year)                      |
| DECEASED:                                                                                                                              | WRIGHT                                  | OF DEATH: May                   |                                   |
| 5. SEX:   6. COLOR OR   7. SINGLE, MARRIED.   8. DATE                                                                                  | OF BIRTH:                               | 9. AGE last birthday IF UNDER   | 1955<br>1 YEAR   IF UNDER 24 HRS. |
| Male Caucasian (Specify): Married 1                                                                                                    | 2 4 70                                  | 35 26 yrs. Months               | Days Hours   Mln.                 |
| IUA. USUAL OCCUPATION (GIVE KIND OF BUSINESS                                                                                           | 2-8-19                                  | (State or foreign country):  12 | 2. CITIZEN OF WHAT                |
| work done during most of working life. OR INDUSTRY:                                                                                    | Indian                                  |                                 | COUNTRY?                          |
| even if retired): Mariner   Mariner Retired                                                                                            | 14. MOTHER'S M                          |                                 | US                                |
|                                                                                                                                        |                                         |                                 |                                   |
| WILLIAM T. WRIGHT  15. WAS DECEASED EYER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.                                               | 17. INFORMANT                           | ADDRESS:                        |                                   |
| (Yes. no. or ymk.) (If Yes, give war or dates                                                                                          |                                         |                                 |                                   |
| Yes of service) WW11 220 34 3721                                                                                                       |                                         | prothy Wright (wif              |                                   |
| 18. MEDICAL CERTIFICAT I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                              | TION                                    |                                 | INTERVAL BETWEEN                  |
| 2 00 0                                                                                                                                 | 1                                       | 110                             | / A                               |
| IMMEDIATE CAUSE (A) Kelicu                                                                                                             | eum le                                  | al Forcome                      | 10mgy                             |
| ANTECEDENT CAUSE (S)                                                                                                                   | +                                       | ll Sarcome                      | -4                                |
| DISEASES OR CONDITIONS, IF ANY. (B)                                                                                                    | melos                                   | loses                           |                                   |
| GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST.                                                                   |                                         |                                 |                                   |
| (C)                                                                                                                                    | 111111111111111111111111111111111111111 |                                 |                                   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE                                                       |                                         |                                 |                                   |
| DISEASE OR CONDITION CAUSING DEATH.                                                                                                    |                                         |                                 |                                   |
| 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATIO                                                                                | N                                       |                                 | 20. AUTOPSY?                      |
|                                                                                                                                        |                                         |                                 | YES NO                            |
| 21A. ACCIDENT WAS UNDERLYING   21B. PLACE (Home, farm, fac<br>OR CONTRIBUTING   CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | etory, 21c. WHERE INJURY OCCU           |                                 | unty) (State)                     |
| 21D. TIME (Month) (Day) (Year) (Hour)   21E INJURY OCCURREI                                                                            | D   21F. HOW DID                        | INJURY OCCUR?                   | STATE OF THE STATE OF             |
| OF INJURY While Not while at work at work                                                                                              | ]                                       |                                 |                                   |
| 22. I hereby certify that I attended the deceased from 2 Au                                                                            | g, 1954, to 4                           | May, 1955, that I la            | st saw the deceased               |
| alive on 4 May 1955, and that death occurred at                                                                                        | 12:55aM, from t                         | he causes and on the date       | e stated above.                   |
| M. E. FLIPSE ICDR MC, USN                                                                                                              |                                         |                                 | JANUAR STORES                     |
| 23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMET                                                                                      |                                         | Y LOCATION (City, town,         |                                   |
| Burial 6-May 1955 Arlington N                                                                                                          | ational Cemet                           | tery, Arlington, V              | irginia                           |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR                                                                                    | 24. FUNERAL I                           | DIRECTOR R. A. Pumph            | ADDRESS                           |

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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BUREAU V. S.

3551 6 YAM

SECENTED

| The                                                                                                                                   | MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 04879                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| WITH UNFADING INK. Supply every item of information carefully. Int. Physicians: please write the causes of death clearly and legibly. | 1. PLACE OF DEATH:  COUNTY MONTGOMERY  COUNTY MONTGOMERY  STATE MARYLAND  CITY (If cutside corporate limits, write RURAL properties for and give nearest (town))  STLVER SPRING  HOSPITAL OR INSTITUTION OR STRING  B. AMARYLAND  CITY (If cutside corporate limits, write RURAL are on and give nearest (town))  HOSPITAL OR INSTITUTION OR STRING  B. AMARYLAND  CITY (If cutside corporate limits, write RURAL are on and give nearest (town))  HOSPITAL OR INSTITUTION OR STRING  B. AMARYLAND  CITY (If cutside corporate limits, write RURAL are on and give nearest (town))  HOSPITAL OR INSTITUTION OR STREET (If rural give location) and give nearest (if rural give location)  STREET ADDRESS 417 HILLMOOR DRIVE  3. NAME OF CHARLES  J. ZEILER  GRACE: (Specify): married Sept. 5, 1916  J. AGE last birthday it users ive work done during most of working life. On INDUSTRY:  OR INDUSTRY:  OR OR 7. SINCLE MARRIED (Sept. 5, 1916  J. AGE last birthday it users ive work done during most of working life. On INDUSTRY:  OR INDUSTRY:  OR OR TOWN SILVER SPRING  STREET ADDRESS 4.7 HILLMOOR DRIVE  STREET ADDRESS 4.7 HILLMOOR DRIVE  J. AGE last birthday it users ive work done during most of working life. One kind of lose kind of working life. On INDUSTRY:  OR INDUSTRY:  OR OR TOWN SILVER SPRING  STREET ADDRESS 4.7 HILLMOOR DRIVE  J. AGE last birthday it users ive work done during most of working life. One kind of Business on Industry in I | ay) (Yes  19  AN IF UNDER HOURS   CITIZEN OF COUNTRY? U.S.A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 4                                                                                                                                     | DISEASE OR CONDITION CAUSING DEATH.  19a. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION  WILL O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 20. AUTO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| OR WRITE                                                                                                                              | OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., etc. INJURY OCCUR?  (IF EITHER, NOTIFY MEDICAL EXAMINER)  21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while at work at work 1954, to Muy 15, 1955 that I last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | saw the dec                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| PLEASE TYPE<br>correct a                                                                                                              | SIGNATURE  SIGNATURE  ADDRESS  DATE  M. D. 8641- Ovlevelle Sc.  23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION WITH STATE AT LINGTON, VIRGINIA COMPANY AT LINGTON COMPAN | e signed<br>May 19<br>sinia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                       | EASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply correct age is especially important. Physicians: please write the c                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | THE TOTAL OF DEATH  Reg. Dist.  1. PLACE OF DEATH:  COUNTY MONTGOMERY  A DATE OF COLOR OR TO SINGLE MARKED  COUNTY MONTGOMERY  COUNTY MONTGOMERY |

| Jy.        | 1. PLACE OF DEATH:                                                                                                                                            | 2. USUAL RESIDENCE (HOME) OF DECEASED:            |                               |  |  |
|------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|-------------------------------|--|--|
| legibl     | COUNTY MONTGOMERY MARYLAND                                                                                                                                    | STATE MARYLAND COUNTY MONTG                       | OMERY.                        |  |  |
|            | CITY (If outside corporate limits, write RURAL) LENGTH OF STAY                                                                                                | CITY(If outside corporate limits, write RURAL and |                               |  |  |
| and        | OR and give nearest town) (in this place)                                                                                                                     | OR                                                | Town !                        |  |  |
|            | 0.000                                                                                                                                                         | DEDVIA DITETIO                                    | 26                            |  |  |
| clearly    | HOSPITAL OR INSTITUTION OR STREET ADDRESS 417 HILLMOOR IRIVE                                                                                                  | ADDRESS 417 HILLMOOR DRIVE                        | - 1                           |  |  |
| 2 1        |                                                                                                                                                               | Last)   4. DATE (Month) (Da                       | y) (Year)                     |  |  |
| death      | DECEASED: (Type or Print) CHARLES J. ZELL                                                                                                                     | ER OF DEATH: MAY 15                               | 1955                          |  |  |
|            | 5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE RACE: WIDOWED, DIVORCED,                                                                                      | OF BIRTH: 9. AGE last birthday IF UNDER 1 YEA     |                               |  |  |
| s of       | male   white   (Specify): married   Sept. 5                                                                                                                   |                                                   |                               |  |  |
| causes     | OA. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired):  Dept. of Hwys. DC Gov                                            | C 3 T 1: 0 7 - 3 C                                | ITIZEN OF WHAT OUNTRY? U.S.A. |  |  |
| the        | 13. FATHER'S NAME:                                                                                                                                            | 14. MOTHER'S MAIDEN NAME:                         |                               |  |  |
|            | Charles A. Zeller                                                                                                                                             | Marie T. Franger                                  |                               |  |  |
| write      | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY ND.                                                                                         | 17. INFORMANT & ADDRESS:                          |                               |  |  |
|            | (Yes, no. or unk.) (If Yes, give war or dates of service) WW II 561-03-9288                                                                                   | Mrs. Dorothy E. Zeller, 417 Hill                  | lmoor Drive                   |  |  |
| please     | 18. MEDICAL CERTIFICATI                                                                                                                                       |                                                   |                               |  |  |
| ole        | I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                            |                                                   | ONSET AND DEATH               |  |  |
| 10         | 420,0                                                                                                                                                         |                                                   |                               |  |  |
| 18:        | IMMEDIATE CAUSE (A) Welle                                                                                                                                     | Myseur deal Infanction                            | approx 2- this                |  |  |
| ia         | ANTECEDENT CAUSE (S)                                                                                                                                          |                                                   | //                            |  |  |
| Physicians | DISEASES OR CONDITIONS, IF ANY. (B) Gridery                                                                                                                   | Myour dial Infantion                              | 3. 4month                     |  |  |
| hy         | GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST.                                                                                          |                                                   |                               |  |  |
|            | (C)                                                                                                                                                           |                                                   |                               |  |  |
| important. | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING                                                                                                                  |                                                   |                               |  |  |
| rts        | TO THE DEATH BUT NOT RELATED TO THE                                                                                                                           |                                                   |                               |  |  |
| odi        | DISEASE OR CONDITION CAUSING DEATH,                                                                                                                           |                                                   |                               |  |  |
| im         | 138. MAJOR PINDINGS OF OPERATION                                                                                                                              |                                                   | 20. AUTOPSY?                  |  |  |
| >          | will or                                                                                                                                                       |                                                   | YES NO                        |  |  |
| especiall  | 21A. ACCIDENT WAS UNDERLYING   21B. PLACE (Home, farm, factory. OR CONTRIBUTING   CAUSE OF DEATH OF INJURY street, office bldg., etc.   INJURY OCCUR? (State) |                                                   |                               |  |  |
| esi        | 21D. TIME (Month) (Day) (Year) (Hour)   21E INJURY OCCURRED   OF INJURY   While   Not while                                                                   | 21F. HOW DID INJURY OCCUR?                        |                               |  |  |
| S          | M. at work at work                                                                                                                                            |                                                   |                               |  |  |
| age        | 22. I hereby certify that I attended the deceased from Daily                                                                                                  | , 1954, to Muy 15, 1955 that I last s             | aw the deceased               |  |  |
| 8          | alive on May 15, 1955, and that death occurred at                                                                                                             |                                                   |                               |  |  |
| ct         | SIGNATURE                                                                                                                                                     | ADDRESS DATE                                      | SIGNED                        |  |  |
| orrect     | Kachh & Fatter M                                                                                                                                              | D. 8641- Ovleavelle Bd.                           | May 15, 5%                    |  |  |
| 00         | 23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETE                                                                                                            | RY OR CREMATORY   LOCATION HOLE TO WHOME          | ounted (State)                |  |  |
|            | REMOVAL (SPECIFY)                                                                                                                                             | t'l. Cemetery Arlington, Virg                     |                               |  |  |
|            | DATE REC'D BY LOCAL   REGISTBAR'S SIGNATURE                                                                                                                   |                                                   |                               |  |  |
|            | DECICEO AD 10                                                                                                                                                 | 8/3/ (-0)                                         | orgia Ave.                    |  |  |
|            | - billow Jates                                                                                                                                                | Wanner to Tumphrey, Silver                        | Spring, Md.                   |  |  |
|            |                                                                                                                                                               |                                                   |                               |  |  |

DECEINED NAV 83 1955

BUREAU V. S.

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